

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07013

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE ENGLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTON HUNTS ENGLAND	
c. LENGTH OF STAY IN 1b LESS 1 HR		d. STREET ADDRESS HILL FARM	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SHARON	First K.	Middle AGEE	Last AGEE
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 FEB 1963
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE CHILD		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) NELLIS AFB, NEVADA
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME WENDELL W. AGEE	
14. MOTHER'S MAIDEN NAME JUNE A. EVANS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT WENDELL W. AGEE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 9160 DUE TO (b) RENAL FAILURE DUE TO (c) HYPERPYREXIA		INTERVAL BETWEEN ONSET AND DEATH 11 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) BURNED CLOTHING IN HOME	
20c. TIME OF INJURY Month, Day, Year Hour 0830 a.m. p.m. 19 MAY 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) ALCONBURY, HUNTS ENGLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O Watkins		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 25 MAY 1967	
23c. NAME OF CEMETERY OR CREMATORY IRON HILL CEMETERY		23d. LOCATION (City, town or county) (State) PIKEVILLE, TENNESSEE	
24. FUNERAL DIRECTOR W.W. CHAMBERS, GO		ADDRESS RIVERDALE, MD	
25a. REC'D BY REGISTRAR MAY 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

01030

Dutton O Watkins
Carpton O Watkins

X

X

X

X

5-22-07
Dutton O Watkins
Carpton O Watkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07031 Item #2c & d Film #0389 6/12/67 DC											
07014											
1. PLACE OF DEATH a. COUNTY Prince Georges						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham					
c. LENGTH OF STAY IN ID 5 days						d. STREET ADDRESS 7151 Hawthorne St.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frederick			First			Middle			Last		
4. DATE OF DEATH May 31 1967			Month			Day			Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/17/84		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Baker				11. BIRTHPLACE (County & State, or foreign country) New York			
12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 678-09-6727		17. INFORMANT Jean Allison		Address 2843 Minn Ave S.E. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pyelonephritis chronic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis											
INTERVAL BETWEEN ONSET AND DEATH 6 weeks											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that (I) (this physician) attended the deceased from 1966 , 19 66 , to May 31 , 19 67 , that (I) (we) last saw the deceased alive on May 31 , 19 67 , and that death occurred at 4:55 PM , from the causes and on the date stated above.											
22a. SIGNATURE 								22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Leon Levitsky, M. D.								22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-3-1967				23c. NAME OF CEMETERY OR CREMATORY Mt Olivet			
23d. LOCATION (City, town or county) (State) Wash, D.C.				23e. REC'D BY REGISTRAR JUN 2 1967				23f. REGISTRAR'S SIGNATURE 			

00031

Prince Georges

Georgie

Prince Georges General Hospital

Frederick

Allison

May

83

2/17/84

xx

White

Male

James
Carr

Physiotherapy Clinic

Marina

rehabilitation

1984

May 31

1:30

1:07

May 31

[Signature]

3408 Prince Island Ave., Prince George, B.C.

John Davidson, M.D.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

07032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07015

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 7301 Forest Road			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Antonetz				4. DATE OF DEATH Month 5 Day 18 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Feb. 1967		9. AGE (In years last birthday) yrs. 3	10. IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Takoma Park, Md		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME ZINK				14. MOTHER'S MAIDEN NAME Cassandra Jo Antonetz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. N/A		17. INFORMANT P.G. WELTARE Beid		Address BRENTWOOD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral bronchopneumonia DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 5-19-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel, Maryland	
24. FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland				25a. REC'D BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07033

07016

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover 16.1	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 7404 B Landover Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dvira Middle Arkinzadeh Last Arkinzadeh		4. DATE OF DEATH Month 5 Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Feb. 1908
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 5 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Iran	
13. FATHER'S NAME Moshe Kaplan		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Son Abraham H. Arkinzadeh		Address 7404B Landover Rd., Landover, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self with rope from hook on door.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:30am p.m. 5-4- 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7404 Landover Rd., Hyattsville, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 5-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-10-67	23c. NAME OF CEMETERY OR CREMATORY Jewish Cemetery	23d. LOCATION (City or Town) (County) (State) Tel Aviv, Israel
24. FUNERAL DIRECTOR Bernard Danzansky & Sons St., NW, Wash. DC		25a. REC'D BY REGISTRAR MAY 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07034					07017				
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF Hospital Andrews					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3332 Clay Street NE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIE First JAMES Middle BANKS JR Last			4. DATE OF DEATH May Month 5 Day 19 67 Year						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Sep 34		9. AGE (In years last birthday) 32 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman		10b. KIND OF BUSINESS OR INDUSTRY US Air Force		11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIE JAMES BANKS SR.				14. MOTHER'S MAIDEN NAME EDNA HENRIETTA BOND					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-48-6234		17. INFORMANT EDNA H. BANKS, Mother---Same as item #2 Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Alcohol withdrawal (2) Seizure disorder Acute pancreatitis									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NA							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3 May , 19 67 , to 5 May , 19 67 , that (I) (we) last saw the deceased alive on 5 May 67 , 19 67 , and that death occurred at 1139 PM from the causes and on the date stated above.									
22a. SIGNATURE Ira A. Gould M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 6 May 67					
22c. PHYSICIAN'S NAME (Type) IRA A. GOULD, CAPT, USAF, MC				22d. ADDRESS USAF Hospital Andrews, Andrews AFB, DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-10-1967		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON		23d. LOCATION (City, town or county) (State) ARLINGTON VIRGINIA			
24. FUNERAL DIRECTOR W. ERNEST JACUN Co. ADDRESS 1432 Yew St. N.W.				25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

STATE OF TEXAS
COUNTY OF DALLAS
IN SENATE
JANUARY 11, 1901

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE

FOR THE YEAR
1900

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FOR THE YEAR
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 14 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 7020 St. Annes Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Barber		4. DATE OF DEATH Month Day Year May 18, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1894
9. AGE (In years lost birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Oscar Reynolds	
14. MOTHER'S MAIDEN NAME Mary Catherine Albin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 214 09 1656A		17. INFORMANT Address Lois J. Brooke Same as #2 (granddaughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion Left DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 17, 1967 , to May 18, 1967 , that (I) (we) last saw the deceased alive on May 18, 1967 , and that death occurred at 2:08 AM , from causes and on the date stated above.			
22a. SIGNATURE Garry Rosenberg		22b. DATE SIGNED 5/18/67	
22c. PHYSICIAN'S NAME (Type) Garry Rosenberg		22d. ADDRESS 6501 Landover Rd. Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/20/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven	23d. LOCATION (City or Town) (County) (State) Hagerstown Md.
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel		25a. REC'D BY REGISTRAR DATE MAY 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

25050

47-48

1996

Wm. C. Brown

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07019

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
c. LENGTH OF STAY IN b. DOA			d. STREET ADDRESS 3715 Kennedy Pl.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Norris Middle A Last Barron			4. DATE OF DEATH Month 5 Day 3 Year 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-14-1910	9. AGE (In years lost birthday) 57 yrs.	10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholster.		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Leonard G. Barron.		14. MOTHER'S MAIDEN NAME Alice Norris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 678 12 3057		17. INFORMANT Margaret E. Whitmore, (same as Item 2) Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH minutes over 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem	
23d. LOCATION (City or Town) Montgomery County, Md.		(County)		(State)	
24. FUNERAL DIRECTOR H. Don DeVol ADDRESS D.C.		25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
H. Don. DeVol, 2222 Wis. Ave. N.W. Wash.		DATE			

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1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 26

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07040

07023

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY 83-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 2500 Van Dorn Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Keith Last Barton				4. DATE OF DEATH Month 5 Day 30 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-1936		9. AGE (In years lost birthday) 31 Yrs.	10. IF UNDER 1 YEAR Months 5 Days 30 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE-RCA CORP.		10b. KIND OF BUSINESS OR INDUSTRY RCA CORPORATION		11. BIRTHPLACE (State or foreign country) FAIRBOLT MINNESOTA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME HERBERT BARTON				14. MOTHER'S MAIDEN NAME LEULLA TYSLAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES.....		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. LEULLA TYSLAND (Mother) BARTON		Address Mason City, Iowa 2020S. HARDING STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 8124 DUE TO Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:01pm 5-30-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 53rd. Pl. & Marlboro Pike, Prince George Co.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5-31-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 3, 1967		23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) MASON CITY, IOWA	
24. FUNERAL DIRECTOR HYSONG'S FUNERAL HOME 1300-N. STREET, N.W.				25a. REC'D BY REGISTRAR JUN 2 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07037

CERTIFICATE OF DEATH

07020

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 16.1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital			d. STREET ADDRESS 5113 Decatur St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Fannie Middle Lee Last Barwick			4. DATE OF DEATH Month 5 Day 19 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-86	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 2 Days 1 Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, or kind if even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Weston Thomas Graves			14. MOTHER'S MAIDEN NAME Betty Hunt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215 54 1147		17. INFORMANT Daughter & Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Constrictive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO Arterio sclerosis (c) General arterio sclerosis					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-29-67 , 19 67 to 5-19-67 , 19 67 , that (I) (we) last saw the deceased alive on May 18 19 67 , and that death occurred at 8:22 M, from causes and on the date stated above.					
22a. SIGNATURE L W Malin			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-19-67
22c. PHYSICIAN'S NAME (Type) L. W. Malin, M.D.			22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100-100000

100-100000



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07033

07021

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Gerald Middle Ray Last Bath			4. DATE OF DEATH Month 5 Day 15 Year 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-1950	9. AGE (In years lost birthday) 16 yrs.	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ray J. Bath			14. MOTHER'S MAIDEN NAME Jrsi C. Huskey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ray J. Bath Address 11605 35th Avenue Beltsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 974x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self with necktie in attic bedroom of home.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 1:00am 5-15- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-15-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 18, 1967	23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery Adelphi, Maryland	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR C. Glen Capter	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07039

07022

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 5103 42nd. Avenue			
3. NAME OF DECEASED (Type or print) William T. Barrett				4. DATE OF DEATH 5 12 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-1887	9. AGE (In years lost birthday) 80 yrs.	10. UNDER 1 YEAR Months Days		10. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseman		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry G Barrett				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Lester A Barrett Address Mt Rainier, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-13-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07041

07024

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Morningside</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Southern Md. Hospital</i>		d. STREET ADDRESS <i>204 Woodland Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Hazel</i> Middle <i>E.</i> Last <i>Beach</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>9</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-13-1912</i>
9. AGE (In years last birthday) <i>55</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>NORTH CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wiley Wiles</i>		14. MOTHER'S MAIDEN NAME <i>Lockie HAM</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Robert H. Beach - Same As Item 2</i>		18. ADDRESS <i>JR.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebrovascular accident</i> DUE TO (c) <i>hypertensive arteriosclerotic disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>20 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/15</i> , 19 <i>67</i> , to <i>5-9</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>5-9</i> , 19 <i>67</i> , and that death occurred at <i>1:50 PM</i> , from causes on and on the date stated above.			
22a. SIGNATURE <i>Alfred R. Lapin MD</i>		22b. DATE SIGNED <i>5-9-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN MD</i>		22d. ADDRESS <i>Clinton, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 13-1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ham Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Lansing, North Carolina</i>	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>1661 Good Hope Rd SE Wash DC</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CELESTIAL DEATH

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Handwritten notes and signatures, including the name "H. H. H." and the date "3-10-1942".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07042

CERTIFICATE OF DEATH

08521

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 36 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial		d. STREET ADDRESS 1017 Ward St.	
3. NAME OF DECEASED (Type or print) First Leonard Middle GLY Last Bedwell		4. DATE OF DEATH Month May Day 28 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-03
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 4 Hours 16 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Race Horse Trainer		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC STABLE	
11. BIRTHPLACE (County & State, or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry G. Bedwell		14. MOTHER'S MAIDEN NAME Lotta L. Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-2926	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA OF COLON DUE TO (c) 1 YR		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 5 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-22 , 19 67 , to 5-28 , 19 67 , that (I) (we) last saw the deceased alive on 5-2 , 19 67 , and that death occurred at 10:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 5-28-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-67	
23c. NAME OF CEMETERY OR CREMATORY Trinity Hill Cem.		23d. LOCATION (City or Town) (County) (State) Laurel P.G. Md.	
24. FUNERAL DIRECTOR Robert M. Mardian		25a. REC'D BY REGISTRAR JUN 15 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

100-100000

STATE OF TEXAS

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IN SENATE,
January 1, 1900.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1899.
BY
J. C. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS
PRINTING CO., 1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07043

07025

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen. Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sena		Middle M.		Last Bindig		4. OATE OF DEATH Month May		Day 17	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. OATE OF BIRTH 1/17/1897		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Post Office		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Utah		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Peter Thompson				14. MOTHER'S MAIOEN NAME Maria Peterson				Address 107-Marie	
15. WAS OCEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Martha E. Krueger-		Blvd., Mankato.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] (Sister-in-law) Minn. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRA CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) OUE TO						INTERVAL BETWEEN ONSET AND OEAH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONOITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OESCRIBE HOW INJURY OCCURREO. (Enter nature of Injury In Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-14-1967, to 5-17-1967, that (I) (we) last saw the deceased alive on May 17 1967, and that death occurred at 2:30 M, from the causes and on the date stated above.									
22a. SIGNATURE Benjamin S. Miller MD						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. OIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. OATE SIGNED 5-18-67	
22c. PHYSICIAN'S NAME (Type) Nalley's						22d. ADDRESS Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. OATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.			
24. FUNERAL OIRECTOR Funeral Home Inc.						25a. REC'O BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL (ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is retained by the hospital or attending physician. Page 2 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07044

07026

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlow Hgts.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen. Hosp.		d. STREET ADDRESS 5948 23rd Pl.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary C. Bivens		4. DATE OF DEATH Month Day Year May 21 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-79
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Loveless		14. MOTHER'S MAIDEN NAME Matilda Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -	
17. INFORMANT CATHYNE A. DOWNS		Address Same As I am 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO cardiac arrest (b) atherosclerotic heart disease (c) atherosclerotic generalized DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 5/21/67, that (I) (we) last saw the deceased alive on 5/21/67, and that death occurred at 1967, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Leon R. Levitsky		22b. DATE SIGNED May 21-67	
22c. PHYSICIAN'S NAME (Type) Dr. Leon R. Levitsky		22d. ADDRESS 3408--Rhode Island Ave Mt. Rainier Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24-1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		25a. REC'D BY REGISTRAR DATE MAY 23 1967	
ADDRESS 1661-Good Hope Rd SE Wash DC		25b. REGISTRAR'S SIGNATURE Charles Judge	

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George Jackson
Marshall
Catherine Jones
James Jones

1967
May 10 1967

May 10 1967
May 10 1967

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #24 Film#G388 5/16/67 pg

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

07045

07027

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District Of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1711 62nd. Avenue				d. STREET ADDRESS 501 60th. St., N.E.			
3. NAME OF DECEASED (Type or print) First Middle Last Frederick William Blackford				4. DATE OF DEATH Month Day Year 5 7 19 67			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1936	9. AGE (In years lost birthday) yrs. 30	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR				10b. KIND OF BUSINESS OR INDUSTRY RENTAL CAR Co.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME HOWARD M. BLACKFORD				14. MOTHER'S MAIDEN NAME ESTELLE P. CORAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. DOROTHY BLACKFORD 501 60TH ST. N.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 12:15 5-7- 19 67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1711 62nd. Ave., Cheverly, Maryland	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 5-8-67			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 5-11-67		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEMETERY	
23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND				25a. REGD. BY REGISTRAR MAY 11 1967			
24. FUNERAL DIRECTOR ADDRESS C Dyson Funeral Home 3015 12th St., N.E.				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07046

07028

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Mexico</u> b. COUNTY <u>Almogorda</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN b. <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Gen. Hospital</u>				e. STREET ADDRESS <u>1616 Jefferson St.</u>			
3. NAME OF DECEASED (Type or print) <u>Edwin H. Boren</u>				4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 May 1910</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>19</u> Min. <u>67</u>		IF UNDER 24 HRS. Months <u>5</u> Days <u>17</u> Hours <u>19</u> Min. <u>67</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVILIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. AIR FORCE</u>			
11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>UNKNOWN</u> <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>RECORDS ANDREW AIR FORCE BASE</u>				Address <u>RECORDS ANDREW AIR FORCE BASE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>H2O1</u> DUE TO <u>Arterio Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Min. unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>5118 11th St. S.E. WASH. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT SAM HOUSTON</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) <u>SAN ANTONIO, TEXAS</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. INC. WASH. D.C.</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07047

CERTIFICATE OF DEATH

08526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2hrs. 14 mins. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 5312 Riverdale Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Borras			4. DATE OF DEATH Month Day Year May 28 1967				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1967	9. AGE (In years last birthday) May yrs.	IF UNDER 1 YEAR Months Days 2 14		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			
13. FATHER'S NAME Joseph Borras			14. MOTHER'S MAIDEN NAME Barbara Ann Sparrough				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 DUE TO Choking Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) physician attended the deceased from May 28, 1967 , to May 28, 1967 , that (I) last saw the deceased alive on May 28, 1967 , and that death occurred at 1:30 PM , from causes and on the date stated above.							
22a. SIGNATURE John R. Buell, M. D.			22b. DATE SIGNED 5/29/67				
22c. PHYSICIAN'S NAME (Type) John R. Buell, M. D.			22d. ADDRESS 8116 Gorman Ave. Laurel, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 6/10/67	23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly	23d. LOCATION (City or Town) (County) (State) PG Maryland				
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland			25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07048

CERTIFICATE OF DEATH

07029

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE New York b. COUNTY Westchester Falmox	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 11 mo. 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eva Fidelis Brady		4. DATE OF DEATH Month Day Year May 21 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1885
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Barrett		14. MOTHER'S MAIDEN NAME INellie Angers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 044-05-4915	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Chronic Cardiac Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/16/66 to 5-20 , 19 67 , that (I) (we) last saw the deceased alive on 5-20 , 19 67 , and that death occurred at 5:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert C. Haile		22b. DATE SIGNED 5-22-67	
22c. PHYSICIAN'S NAME (Type) Robert C. Haile		22d. ADDRESS 35 NY AVE NW WASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-67	
23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City or Town) (County) (State) Danbury, Connecticut	
24. FUNERAL DIRECTOR GASCH'S		25. RECEIVED BY REGISTRAR MAY 24 1967	
26. ADDRESS 4739 Baltimore Ave. Hyattsville, Maryland		27. REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07043

07030

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 5814 Lamont Drive	
3. NAME OF DECEASED Filippa, Maria ^{First} Eugenia ^{Middle} DiGregorio ^{Last} Brancato (Type or print)		4. DATE OF DEATH Month May Day 5 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Palermo, Italy		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Pasquale DiGregorio		14. MOTHER'S MAIDEN NAME Ignazia Buscemi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Settimo E Brancato		Address Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral pyonephrosis DUE TO (c) Rt pyonephrosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-4 , 19 65 , to 5-6 , 19 67 , that (I) (we) last saw the deceased alive on 5-6 19 67 , and that death occurred at 4:30 M, from causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 5-8-67	
22c. PHYSICIAN'S NAME (Type) George Hageage		22d. ADDRESS Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR MAY 10 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07050

CERTIFICATE OF DEATH

07031

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 16.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission): a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3700 Oliver St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Broadwater		4. DATE OF DEATH Month 5 Day 19 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1916
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 3 Days 18 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) 1st Methodist Church		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Superintendant	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert S. Edden		14. MOTHER'S MAIDEN NAME Hildegard Merkle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Medical Records & Pre-admission chart	
17. INFORMANT Medical Records & Pre-admission chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary failure 1905 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA lung DUE TO (c) MALIGNANT MELANOMA - Bowel		INTERVAL BETWEEN ONSET AND DEATH 3 mo 18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) APRIL		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 mo, 1966 , to 5-19-67 , 19__, that (I) (we) last saw the deceased alive on 5-19-67 19__, and that death occurred at 1:20 PM , from causes and on the date stated above.			
22a. SIGNATURE R. F. Wilkinson		22b. DATE SIGNED 5-19-67	
22c. PHYSICIAN'S NAME (Type) R. F. Wilkinson, M.D.		22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07051

07032

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 2515 Jameison Street	
3. NAME OF DECEASED (Type or print) First Frederick Middle Thomas Last Brooks		4. DATE OF DEATH Month May Day 14 Year 1967	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1940
9. AGE (In years last birthday) yrs. 26		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Biologist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Brooks		14. MOTHER'S MAIDEN NAME Floaia Walker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary E. Brooks-wife		Address 2515 Jameison	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Laceration of right carotid artery DUE TO (c) Trauma - auto accident			INTERVAL BETWEEN ONSET AND DEATH minutes minutes minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which went out of control and struck house.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5:33AM 5-14-67 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 23rd Parkway 100 ft. s. of Catskill St. P.G.		20f. (City or town) (County) (State) Riverdale, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 5-14-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/67	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.		23d. LOCATION (City or Town) (County) (State) Maryland	
24. FUNERAL DIRECTOR Stewart		25a. REC'D BY REGISTRAR MAY 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1533



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines, possibly a list or a set of instructions, arranged in a structured format. Some words are difficult to discern but may include terms like 'Page', 'Date', 'Time', 'Location', and 'Remarks'. There are also some numbers and possibly names scattered throughout the lines.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

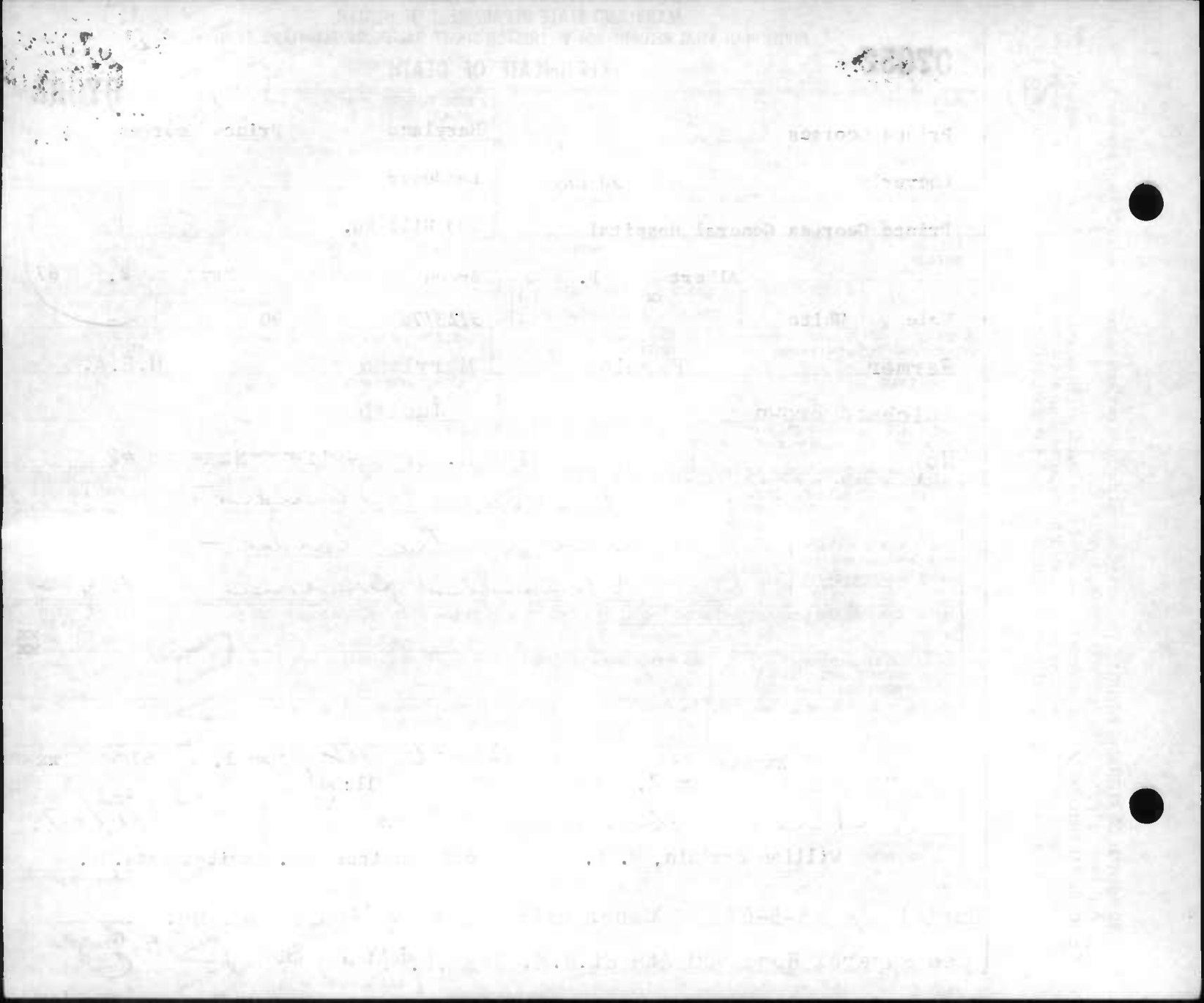
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07052

CERTIFICATE OF DEATH

07033

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 50 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS 303 Hill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Albert B. Brown		4. DATE OF DEATH Month Day Year May 2, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/76
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Brown		14. MOTHER'S MAIDEN NAME Judith -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Iva M. Brown-wife		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular Accident. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anticoagulant Cardio - DUE TO (c) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 6, 1952 , to May 2, 1967 , that (I) (we) saw the deceased alive on May 2, 1967 , and that death occurred at 11:30 A. from causes on and on the date stated above.			
22a. SIGNATURE William Brainin M.D.		22b. DATE SIGNED 5/2/67.	
22c. PHYSICIAN'S NAME (Type) William Brainin, M. D.		22d. ADDRESS 6124 Central Ave. Capitol Hgts. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-5-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR MAY 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07053

CERTIFICATE OF DEATH

07034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		d. STREET ADDRESS 4824 EASTERN LANE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BROWN, NORMAN. L.		4. DATE OF DEATH Month Day Year 28 MAY 1967	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Aug 26
9. AGE (In years lost birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US ARMY (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (County & State, or foreign country) PINEVILLE, LA		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME WILLIAM A. BROWN		14. MOTHER'S MAIDEN NAME LONIA HUNNICUT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 437303533	
17. INFORMANT DOROTHY S. BROWN-WIFE-SAME AS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 Myocardial Infarction IMMEDIATE CAUSE (a) DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 May, 1967 , to 28 May, 1967 , that (I) (we) last saw the deceased alive on 28 May, 1967 , and that death occurred at 20:55 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard J. Wiseley M.D.		22b. DATE SIGNED 28 May 1967	
22c. PHYSICIAN'S NAME (Type) RICHARD J. WISELEY, CAPT (MC)		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 1967	23c. NAME OF CEMETERY OR CREMATORY Alexandria Louisiana	23d. LOCATION (City or Town) (County) (State) Alexandria, Louisiana
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR DATE MAY 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07054

07035

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University, Park		d. STREET ADDRESS 4002 Beachwood Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georg's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Betty Last Brown		4. DATE OF DEATH Month 5 Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1877
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months 5 Days 25 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? New York	
13. FATHER'S NAME Oscar Hinricks		14. MOTHER'S MAIDEN NAME Mary Stanley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Elizabeth Henson		Address Same as #2 (daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 , to 5-25, 1967 that (I) (we) last saw the deceased alive on 5-25 1967 , and that death occurred at 9:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren		22b. DATE SIGNED 5-26-67	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/29/67	
23c. NAME OF CEMETERY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

STATE OF TEXAS

1904

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State of _____

County of _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23c & d Film #G388 5/15/67 pc
CERTIFICATE OF DEATH

07055

07036

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 hrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Chelmont Lane 4012 Chelmont			
3. NAME OF DECEASED (Type or print) First Mary Middle K Last Buch				4. DATE OF DEATH Month May Day 10 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Aug., 1888	9. AGE (In years last birthday) 77 78	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lancaster Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fenninger				14. MOTHER'S MAIDEN NAME Amanda Krider			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 173-03-1543D		17. INFORMANT Address 4012 Chelmont Ln Mrs. William H. Clifford Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial Infarction DUE TO (c) Septicemia Pericarditis Pleuritis Meningitis						INTERVAL BETWEEN ONSET AND DEATH 1 day.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A. Diabetes Mellitus B. Chronic Renal Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT , 19 65 to May 10 , 1967, that (I) (we) last saw the deceased alive on May 10 , 1967, and that death occurred at 9, 15 PM from causes and on the date stated above.							
22a. SIGNATURE Norman K Bohrer M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 11, 1967.	
22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M. D.				22d. ADDRESS 3231 Superior Lane, Bowie, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/13/1967		23c. NAME OF CEMETERY OR CREMATORY East Harrisburg		23d. LOCATION (City or Town) (County) (State) Harrisburg, Dauphin, Penna.	
24. FUNERAL DIRECTOR Walter G. ...				25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07056

07037

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Maryland</u> d. STREET ADDRESS <u>10611 - Brandywine Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MICHAEL T. BUCKLER</u> First Middle Last			4. DATE OF DEATH <u>May 26 1967</u> Month Day Year				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19-1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>US. Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agricultural Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Philip A. Buckler</u>			14. MOTHER'S MAIDEN NAME <u>Delphine Marr</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Evelyn E. Buckler (Wife) Same as # 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>3 MIN.</u> <u>7 DAYS</u> <u>10 YRS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COMBINATION GIVEN IN PART I. <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year <u>None</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>			
20f. (City or town) (County) (State) <u>None</u>		21. I certify that (this hospital) attended the deceased from <u>May 19, 1967</u> to <u>Present</u> that (we) last saw the deceased alive on <u>May 26 19 67</u> , and that death occurred at <u>8:15 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.			22b. DATE SIGNED <u>5/26/67</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		
22d. ADDRESS <u>8808 BRANCH AVE. - CLINTON, MD.</u>			22e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 29th 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Clinton, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>Simmons Bros. 1661-Gd. Hope RD. SE Wash., DC</u>					
25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03000

CENTRAL BANK OF DENMARK

1914

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07057

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07038

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 1838 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Edward Burch			4. DATE OF DEATH Month Day Year 5 27 19 67		
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-08		9. AGE (In years lost birthday) yrs. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shear Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel Fabricated Corp.	11. BIRTHPLACE (State or Territory) Marion County, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charlie Burch			14. MOTHER'S MAIDEN NAME Etta Davis (Burch)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 4/28/1942		16. SOCIAL SECURITY NO. 249-42-0220	17. INFORMANT Address Marie Leonard Burch		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma - auto accident DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver of car involved in collision			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3:15am 5-27- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Woodrow Wilson Bridge, Prince George's, Md.		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 5-27-67	
23a. BURIAL CREMATION (Type) BURIAL		23b. DATE THEREOF June 4 1967		23c. NAME OF CEMETERY OR CREMATORY Church	
24. FUNERAL DIRECTOR E.T. Murray		ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR DATE JUN 1 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07058

CERTIFICATE OF DEATH

02039

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1400 Merrimac Drive	
3. NAME OF DECEASED (Type or print) Benjamin Smith Carrico		4. DATE OF DEATH Month May Day 27 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Mar 2, 1895		9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (County & State, or foreign country) Warrenton, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Silas Carrico		14. MOTHER'S MAIDEN NAME Dora Shaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-10-9269		17. INFORMANT Mary E. Carrico	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Arteriosclerosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Artery Disease DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 9 years 12 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Nov. , 19 55 , to May 27, 1967 , that (I) (we) saw the deceased alive on May 18, 1967 , and that death occurred at M , from causes and on the date stated above		22a. SIGNATURE Lawrence J. Thomas	
22b. DATE SIGNED May 29, 1967		22c. PHYSICIAN'S NAME (Type) Lawrence J. Thomas		22d. ADDRESS 1712 9. St., N. W., Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 30, 1967		23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	
23d. LOCATION (City or Town) (County) (State) Manassas, Virginia		24. FUNERAL DIRECTOR Clark E. Warner		25a. RECEIVED BY REGISTRAR JUN 2 1967	
25b. REGISTRAR'S SIGNATURE Warner E. Humphrey, Inc. Silver Spring, Md.		25c. REGISTRAR'S SIGNATURE Warner E. Humphrey, Inc. Silver Spring, Md.		25d. REGISTRAR'S SIGNATURE Warner E. Humphrey, Inc. Silver Spring, Md.	

07057

MINUTE OF DEATH

07057

Form with multiple sections and fields, including a large central area with faint text and a signature line at the bottom.

1. Name of Deceased: _____

2. Date of Death: _____

3. Place of Death: _____

4. Cause of Death: _____

5. Signature of Doctor: _____

6. Signature of Witness: _____

7. Signature of Coroner: _____

8. Signature of Medical Examiner: _____

9. Signature of Pathologist: _____

10. Signature of Forensic Scientist: _____

11. Signature of Toxicologist: _____

12. Signature of Anthropologist: _____

13. Signature of Entomologist: _____

14. Signature of Botanist: _____

15. Signature of Zoologist: _____

16. Signature of Geologist: _____

17. Signature of Meteorologist: _____

18. Signature of Astronomer: _____

19. Signature of Chemist: _____

20. Signature of Physicist: _____

21. Signature of Biologist: _____

22. Signature of Ecologist: _____

23. Signature of Environmental Scientist: _____

24. Signature of Public Health Officer: _____

25. Signature of Health Department: _____

26. Signature of Police Department: _____

27. Signature of Sheriff's Office: _____

28. Signature of District Attorney: _____

29. Signature of County Clerk: _____

30. Signature of State Registrar: _____

31. Signature of National Health Service: _____

32. Signature of World Health Organization: _____

33. Signature of United Nations: _____

34. Signature of International Red Cross: _____

35. Signature of International Committee of the Red Cross: _____

36. Signature of International League of Red Cross Societies: _____

37. Signature of International Federation of Red Cross and Red Crescent Societies: _____

38. Signature of International Association of Red Cross Societies: _____

39. Signature of International Association of Red Crescent Societies: _____

40. Signature of International Association of Red Society of Children: _____

41. Signature of International Association of Red Society of Women: _____

42. Signature of International Association of Red Society of Youth: _____

43. Signature of International Association of Red Society of Students: _____

44. Signature of International Association of Red Society of Teachers: _____

45. Signature of International Association of Red Society of Parents: _____

46. Signature of International Association of Red Society of Grandparents: _____

47. Signature of International Association of Red Society of Great-Grandparents: _____

48. Signature of International Association of Red Society of Great-Great-Grandparents: _____

49. Signature of International Association of Red Society of Great-Great-Great-Grandparents: _____

50. Signature of International Association of Red Society of Great-Great-Great-Great-Grandparents: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07059

CERTIFICATE OF DEATH

07040

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN 1b 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Convalescent Center		d. STREET ADDRESS 9607 48th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTELLE Middle E. Last CARROLL		4. DATE OF DEATH Month May Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 13, 1897
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.	11. IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles B. Baker		14. MOTHER'S MAIDEN NAME Mabel Ingledue	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 07 5424B	
17. INFORMANT Herbert A. Carroll		Address Same as #2 (husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 333X DUE TO General arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension (c) and arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 to May 15, 1967 , that (I) (we) last saw the deceased alive on May 11, 1967 , and that death occurred at 11:05 M, from causes and on the date stated above.			
22a. SIGNATURE L W Malin		22b. DATE SIGNED 5-15-67	
22c. PHYSICIAN'S NAME (Type) L W MALIN MD		22d. ADDRESS Beverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07060

07041

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lee Middle G. Last Cary				4. DATE OF DEATH Month 5 Day 15 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 March 1907		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leslie Cary				14. MOTHER'S MAIDEN NAME Lula ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Edna M. Cary (Wife) Address Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 20 yrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 5-15-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19-1967		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Louisville, Kentucky	
24. FUNERAL DIRECTOR Simmons Bros. ADDRESS 1661-Good Hope Rd SE Wash DC				25a. REC'D BY REGISTRAR MAY 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

076-1010

076-1010

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. It also includes a list of the personnel involved in the project.

2. The second part of the report is a description of the methodology used in the project. It includes a description of the data collection methods, the data analysis methods, and the results of the project.

3. The third part of the report is a description of the results of the project. It includes a description of the findings, the conclusions, and the recommendations.

4. The fourth part of the report is a description of the conclusions and recommendations. It includes a description of the findings, the conclusions, and the recommendations.

5. The fifth part of the report is a description of the conclusions and recommendations. It includes a description of the findings, the conclusions, and the recommendations.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07061

CERTIFICATE OF DEATH

07042

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 31 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6309 Foots St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Christine P. Caudill				4. DATE OF DEATH Month Day Year May 5 19 67			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH May 4, 1967	
9. AGE (In years last birthday) 1+		IF UNDER 1 YEAR Months Days Hours Min. 1+		11. BIRTHPLACE (County & State, or foreign country) Md Pro Geo County		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Md Pro Geo County	
13. FATHER'S NAME Russell Caudill				14. MOTHER'S MAIDEN NAME Patrice H Hawes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Russell Caudill Address Seat Pleasant, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH 31 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from May 4 , 19 67 , to May 5 , 19 67 that (I) (we) last saw the deceased alive on May 5 , 19 67 , and that death occurred at 130 P M, from causes and on the date stated above.							
22a. SIGNATURE Milos Janga				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 5, 1967	
22c. PHYSICIAN'S NAME (Type) Milos Janga, M. D.				22d. ADDRESS 7403 Varnum St. Landover Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 8 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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Form with multiple sections for death certificate, including fields for name, date, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.

Vertical text on the right margin, likely bleed-through from the reverse side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07062

CERTIFICATE OF DEATH

07043

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 6606 Fairwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Robert J. Chamberlain			4. DATE OF DEATH Month Day Year May 28, 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/03	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. TREASURY		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT		11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.	
13. FATHER'S NAME Robert J. Chamberlain			14. MOTHER'S MAIDEN NAME BLANCH GARRETT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-48-5871	17. INFORMANT Elsie E Chamberlain Address SEE #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) circulatory failure 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) staph. abscess of lungs DUE TO (c) Diabetes mellitus.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 7, 1967 , to May 28, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 28, 1967 , and that death occurred at 1:10 AM from causes and on the date stated above.					
22a. SIGNATURE B. Bahrami M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 29, 1967
22c. PHYSICIAN'S NAME (Type) B. Bahrami M.D.			22d. ADDRESS 3003 Naylor Rd., N.E., D.C. 20020		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORY OAK WOOD	23d. LOCATION (City or Town) (County) (State) Falls Church, VA.		
24. FUNERAL DIRECTOR W.H. Chambers		ADDRESS Riverdale Md.		25a. REC'D BY REGISTRAR JUN 1 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

07002

CERTIFICATE OF DEATH

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Prince George

Married

Prince George

of days

landover

Prince George General Hospital

6800 Fairview Road

Robert

Chapman

May 28, 1957

Male

White

xx

012303

03

xx

MAY 28, 1957

1:00 PM

MAY 28, 1957

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MAY 28, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07063

CERTIFICATE OF DEATH

07044

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Okon Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens</u>		d. STREET ADDRESS <u>5205 Dunwoody Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia H. Conklin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14 1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Long</u>		14. MOTHER'S MAIDEN NAME <u>Dean Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-24-8958-B</u>	
17. INFORMANT <u>Joseph B Norris same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1992</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>ABDOMINAL CARCINOMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 MIN.</u> <u>1 MONTH</u> <u>60 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> a.m. <u>None</u> p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>None</u>	20f. (City or town) (County) (State) <u>None</u>
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1967</u> , to <u>Present</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>6:39 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u>		22b. DATE SIGNED <u>5/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. MD.</u>		22d. ADDRESS <u>8808 OLD BRANCH AVE CLINTON MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES, MARYLAND</u>
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u> <u>4308 SUITLAND ROAD, SUITLAND, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

07083

CENTRAL OF PENN

07083

63-188-1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08547

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 42 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 609 Irving St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle L. Last Cooper				4. DATE OF DEATH Month 5 Day 29 Year 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/1900		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown - retired		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Cooper				14. MOTHER'S MAIDEN NAME Mollie Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 042-18-1732		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung, with wide-spread metastases 162-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that # (this hospital) attended the deceased from 4/17/ 1967 , to 5/29/ 1967 , that # (we) last saw the deceased alive on 5/29/ 19 67 , and that death occurred at 7:45P M , from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/29/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6-2-67		23c. NAME OF CEMETERY OR CREMATORY HERMONY MEMORIAL LENOVER MD.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR UNIVERSAL FUNERAL HOME 8164 ST NE.				25a. REC'D BY REGISTRAR DATE JUN 12 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07045

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anthony Middle Louis Last Costantino				4. DATE OF DEATH Month 5 Day 5 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889 10-16-1891	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 75 Days 77		IF UNDER 24 HRS. Hours 77 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Francis Costantino				14. MOTHER'S MAIDEN NAME Grace M. Coulatto			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-20-4544		17. INFORMANT Address Mrs. Rose V. Costantino (above ad-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 5-6-67					
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07065

CERTIFICATE OF DEATH

07046

1. PLACE OF DEATH a. COUNTY <u>PG.</u> <u>Riverdale,</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale,</u> <u>Md.</u>		c. LENGTH OF STAY IN 1b <u>2Days.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale,</u> <u>Md.</u>		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Hospital,</u>		d. STREET ADDRESS <u>6102 63rd Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>M</u> Last <u>Crawley</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1st</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-78</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Armiger, Mr. William</u>		14. MOTHER'S MAIDEN NAME <u>Campbell, Mary ann.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>579 42 2999</u>	
17. INFORMANT <u>Eugene Leland Hospital, 4408 Queensbury Rd.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arterio sclerosis</u> DUE TO (c) <u>interfering</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 29</u> , 19 <u>67</u> , to <u>May 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 1</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L W MALON</u>		22b. DATE SIGNED <u>5-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L W MALON M.D.</u>		22d. ADDRESS <u>Riverdale, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyattsville P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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George Washington
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07066

CERTIFICATE OF DEATH

07047

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Convalescent Center		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 473	
3. NAME OF DECEASED (Type or print) Henrietta Cunningham First Middle Last NMI Cunningham		d. STREET ADDRESS 1263 Monroe St., N. E.	
4. DATE OF DEATH Month May Day 5 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/1877
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward McBride Arnn		14. MOTHER'S MAIDEN NAME Martha Stepp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579-50-8548-A	
17. INFORMANT Edward P. Cunningham		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF PHARYNX 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 APRIL , 19 67 , to 5 MAY , 19 67 that (I) (we) last saw the deceased alive on 5 MAY , 19 67 , and that death occurred at 4:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Howard M. Tanning		22b. DATE SIGNED MAY 5, 1967	
22c. PHYSICIAN'S NAME (Type) Howard M. Tanning		22d. ADDRESS Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/67	
23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Gawlers Funeral Home		25a. REC'D BY REGISTRAR Wash., D. C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 10 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07067

CERTIFICATE OF DEATH

07048

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hghts. d. STREET ADDRESS 2341 Lyon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Anna J. Daniels			4. DATE OF DEATH Month Day Year May 22, 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1900	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 16.1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Operator		11. BIRTHPLACE (County & State, or foreign country) Scotland	
13. FATHER'S NAME Neil Grant			14. MOTHER'S MAIDEN NAME Leonie ?		
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address Neil Daniel, Son, Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 421.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Pulmonary emphysema DUE TO (c) Chronic bronchitis & emphysema					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 5/1/67 , 19 67 to 5/22 , 19 67 , that (I) (we) lost saw the deceased alive on 5/22 , 19 67 , and that death occurred at 1:55 p.m. from causes and on the date stated above.					
22a. SIGNATURE Leon R. Levitsky 22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M. D.			22b. DATE SIGNED May 22, 1967 22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/25/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland			25a. REC'D BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07068

CERTIFICATE OF DEATH

07049

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NORTH CAROLINA b. COUNTY 703	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. LENGTH OF STAY IN 1b 2mo, 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 628 FETCHET ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SALLY ANN DARNELL		4. DATE OF DEATH Month Day Year MAY 9 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 AUG 1931
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES FREDERICK DONOVAN		14. MOTHER'S MAIDEN NAME ISABEL FRANCES SEALE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. 029-24-1186	
17. INFORMANT HUSBAND		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC & RESPERATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>FAR ADVANCED CANCER OF BREAST WITH METASTASIS</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>3 March</u> , 19 <u>67</u> , to <u>9 May</u> , 19 <u>67</u> that (X) (we) last saw the deceased alive on <u>9 May</u> , 19 <u>67</u> , and that death occurred at <u>7:35 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <i>Dixon Yeste</i>		22b. DATE SIGNED 9 May 67.	
22c. PHYSICIAN'S NAME (Type) DIXON YESTE, CAPT, USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/13/67	
23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY		23d. LOCATION (City or Town) (County) (State) ROANOKE, VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR MAY 15 1967 DATE	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07069

CERTIFICATE OF DEATH

07050

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. LENGTH OF STAY IN 1b <u>Week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7121 Cabot Street</u>		d. STREET ADDRESS <u>Route #6- Frederick, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ursula</u> Middle <u>B.</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 5, 1895</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Elk Garden, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Patrick Henry Brown</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Theresa Burke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 48 9519</u>	
17. INFORMANT <u>Mrs. Charles Watkins, Route #6, Frederick, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>64</u> to <u>May 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 8</u> , 19 <u>67</u> , and that death occurred at <u>1P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry V Chase</u>		22b. DATE SIGNED <u>5/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase M.D.</u>		22d. ADDRESS <u>804 Toll House Ave Frederick, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u>
24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07070

CERTIFICATE OF DEATH

07051

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randle Cliffs, Chesapeake Beach</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LYLA</u> First <u>PEARL</u> Middle <u>DEAN</u> Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			4. DATE OF DEATH <u>MAY</u> Month <u>20</u> Day <u>19</u> Year <u>67</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Calvert County, Md.</u>			
13. FATHER'S NAME <u>Emory Gilburn</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Lyons</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-05-2947</u>		17. INFORMANT <u>Mrs. Hilda Friedler, Ches. Beach, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4221 DUE TO <u>Massive Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> c) <u>20 yrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month Day Year <u>none</u>		20d. INJURY OCCURRED <u>none</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>none</u>			
20f. (City or town) (County) (State) <u>none</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1967</u> to <u>Present</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>5/20/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. MD.</u>				22d. ADDRESS <u>8808 OLD BRANCH AVE. CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>May 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cem. Alum. Saint Calvert Md.</u>			
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home (Spring)</u>		25a. REC'D BY REGISTRAR <u>MAY 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10070

UNITED STATES OF AMERICA

10070

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
07071					07052					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
e. COUNTY Prince Georges MARYLAND					a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Langley Park					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Langley Park 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1311 Merrimac Drive					d. STREET ADDRESS 1311 Merrimac Drive					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last Louis R DENNIS					Month Day Year May 12 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1899		9. AGE (In years last birthday) yrs. 67		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney (retired)			10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.			11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis R. Dennis					14. MOTHER'S MAIDEN NAME Rosa Lee Davenport					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. 578-54-2774		17. INFORMANT Louis R. Dennis, Jr.					
					Address 6106 Madison St. East Riverdale Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 163X Rupture Aneurysme										
DUE TO arterial sclerosis Cardio Vascular dr										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Carcinoma										
DUE TO (c) pulmonary Embolism										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 1966 to 5-12-1967, that (I) (we) last saw the deceased alive on 5-9-1967, and that death occurred at A.M., from the causes and on the date stated above.										
22a. SIGNATURE O. HANNES SAHAKYAN					22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) O. HANNES SAHAKYAN					22d. ADDRESS 6001 Landover Rd. Chevy Chase					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/16/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company					ADDRESS Washington, DC		25a. REC'D BY REGISTRAR MAY 16 1967			
					25b. REGISTRAR'S SIGNATURE Charles Judge					

05050

4503

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07072

07053

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 441 H St., N. W.			
3. NAME OF DECEASED (Type or print) First Richard Middle J. Last Dickinson				4. DATE OF DEATH Month 5 Day 3 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/28/1905	9. AGE (In years lost birthday) yrs. 62	IF UNDER 1 YEAR Months 47 Days 3	IF UNDER 24 HRS. Hours 3 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Sta. Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard L. Dickinson				14. MOTHER'S MAIDEN NAME Lillie M. Payne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 266-10-2115		17. INFORMANT Decedent			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis with arteriosclerotic cardiovascular disease and peripheral vascular insufficiency.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that xx (this hospital) attended the deceased from 4/21/ , 19 67 , to 5/3/ , 19 67 , that he (we) last saw the deceased alive on 5/3/ , 19 67 , and that death occurred at 9:00M , from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 5/3/67			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Family Cemetery		23d. LOCATION (City or Town) (County) (State) Spotsylvania County Va.			
24. FUNERAL DIRECTOR F. Gasch's Sons				25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE Charles J. ...	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07073

CERTIFICATE OF DEATH

07054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 30 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 4509 Oliver St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERICO XXX Di Paolo First Middle Last		4. DATE OF DEATH Month Day Year May 10 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1 1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernardo DiPaolo		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 036-16-2510	
17. INFORMANT Mrs. Margaret E. DiPaolo		18. 4509 Oliver St. Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH About 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 to 5-10 , 19 67 , that (I) (we) last saw the deceased alive on 5-9 19 67 , and that death occurred at 2:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Ottavio Gelmi		22b. DATE SIGNED May 10, 1967	
22c. PHYSICIAN'S NAME (Type) Ottavio Gelmi, M. D.		22d. ADDRESS 916 19th St., N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-13-1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR Robert E. Dailley & Son		25a. REC'D BY REGISTRAR MAY 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03073

CERTIFICATE OF DEATH

State of New York

County of New York

In Town of

City of New York

Deceased

White

Male

Married

Age

Years

Dec. 10, 1911

at New York

Witnessed by

Physician

Witnessed by

Physician

Witnessed by

Physician

Witnessed by

Physician

Witnessed by

Physician

Witnessed by

Physician

Witnessed by

Physician

Witnessed by

Physician

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8, 11, 12, 13, 14 & 17 & 23c & d Film #G389 6/12/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07055

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bernice Middle Dixon Last Dixon				4. DATE OF DEATH Month 5 Day 27 Year 19 67			
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/44		9. AGE (In years last birthday) 22 yrs		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Garrett				14. MOTHER'S MAIDEN NAME Dorothy Dixon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Lubie Dixon Rt. 2 Box 591 A Grifton, N.C. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Compound skull fracture DUE TO (c) Trauma - auto accident							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in collision					
20c. TIME OF INJURY Month, Day, Year 3:15am 5-27 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, public bldg., etc.) Woodrow Wilson Bridge, Prince George's, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 5-28-67			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-29-67		23c. NAME OF CEMETERY OR CREMATORY Ayden		23d. LOCATION (City or town) N.C. (County) (State)	
24. FUNERAL DIRECTOR Floyd 389 B.I. on Wash. DC.				25a. REC'D BY REGISTRAR JUN 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

665017

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07075

07056

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 68 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 2432 Irving St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle P. Last Dixon				4. DATE OF DEATH Month May Day 17 Year 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1885	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Dade				14. MOTHER'S MAIDEN NAME Jane Ford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No - - -		16. SOCIAL SECURITY NO. 577-34-7271		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis with uremia 4290 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with fibrillation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3/10 , 19 67 , to 5/17 , 19 67 , that (X) (we) last saw the deceased alive on 5/17/67 1967, and that death occurred at 10A M, from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 5/17/67		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-22-67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR R. Hines Funeral Home				25a. REGISTERAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten signature: *James M. Smith*

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11,12,13,14 & 17 & 23c Film #G389 6/12/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07057

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia d. STREET ADDRESS 3418 Carlisle Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Laurine Dixon		4. DATE OF DEATH Month Day Year 5 27 19 67	
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-46
9. AGE (In years last birthday) yrs. 21		10. IF UNDER 1 YEAR Months Days Hours Min. 21	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) N.C.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Lubie Dixon		15. MOTHER'S MAIDEN NAME Olivia Dixon	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Lubie Dixon Rt.		Address 591A Grifton, N.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of Brain 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple occipital skull fractures DUE TO (c) Trauma - auto accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in collision	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 3:15am 5-27 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 2	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodrow Wilson Bridge, Prince George's, Md.		20f. (City or town) (County) (State) Prince George's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 5-28-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-29-67		23b. DATE THEREOF 5-29-67	
23c. NAME OF CEMETERY OR CREMATORY Ayden		23d. LOCATION (City or town) (County) (State) Ayden, N.C.	
24. FUNERAL DIRECTOR Prozac 389 B.I. on NW Wash. St.		25. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07077

CERTIFICATE OF DEATH

07058

1. PLACE OF DEATH a. COUNTY <u>PR. Georges.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Hosnital</u>		d. STREET ADDRESS <u>7003-A St. SE.</u>	
3. NAME OF DECEASED (Type or print) First <u>Audrey</u> Middle <u>C</u> Last <u>Dodson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1911</u>
9. AGE (In years, lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR <u>55</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Magner</u>		14. MOTHER'S MAIDEN NAME <u>Annie Russell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Martha Baker</u>		Address <u>(daughter)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Systolic shock</u> <u>260 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Infected stump of thigh amputation</u> DUE TO (c) <u>Peripheral vascular gangrene</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>72 hrs</u> <u>59 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Myocardial fibrosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/23/67</u> , 19 <u>67</u> , to <u>5/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John H. Bayly</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/24/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland. Md</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		ADDRESS <u>Washington, D.</u>	
25a. REC'D BY REGISTRAR <u>MAY 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DECLARATION OF DEATH

05077

[Faint, mostly illegible text and markings on a form, possibly containing a signature and various fields.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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VR A15ME (9)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07059

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6703 Goodluck Road			e. STREET ADDRESS 6703 Goodluck Road		
3. NAME OF DECEASED (Type or print) Joseph Murgatroyd Dolbey			4. DATE OF DEATH 5 7 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 June 1884	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOOL MAKER		10b. KIND OF BUSINESS OR INDUSTRY ERCO CORP	11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-03-2124	17. INFORMANT MRS. WALTER MARTIN Address 6809 GOODLUCK RD, EAST RIVERDALE, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH minutes over 3 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF MAY 11 1967	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	23d. LOCATION (City or Town) BLADENBURG	(County) (State) MD
24. FUNERAL DIRECTOR W.W. Chambers Co			25. REC'D BY REGISTRAR Charles Judge		
ADDRESS Riverdale, Md			DATE MAY 15 1967		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07073

07060

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN IS D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 2801 Nicholson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorin Middle H. Last Drennan				4. DATE OF DEATH Month May Day 5 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 May 1903	9. AGE (In years lost birthday) yrs. 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Electro type		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 375-01-2503		17. INFORMANT Lorin H. Drennon Jr., 11805 Milbern, Drive Address Potomac, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Oesophageal varices DUE TO (c) Cirrhosis of liver						INTERVAL BETWEEN ONSET AND DEATH minutes unknown over 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8 May 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pr. Geo. Md.	
24. FUNERAL DIRECTOR F. Gasch & Sons, Hyattsville, Md. ADDRESS				25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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• *Journal of Management Education* 25(1): 10-17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07080

CERTIFICATE OF DEATH

07061

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE = Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 31 minutes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		d. STREET ADDRESS 6152 Springhill Ter., Apt. 303	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ERIK ALEXIS Emerson		4. DATE OF DEATH Month Day Year May 18 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1967
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 16 1 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) Cheverly Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Capers Emerson		14. MOTHER'S MAIDEN NAME Joan Louise Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Capers Emerson		Address 6152 Spring Hill Terrace Greenbelt Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS NEONATORUM - DILAT 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 16	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (physician) attended the deceased from May 18, 1967 , to May 18, 1967 , that (I) (was) last saw the deceased alive on May 18, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Louis H. Moody, Jr., M.D.		22b. DATE SIGNED 5-20-67	
22c. PHYSICIAN'S NAME (Type) Louis H. Moody, Jr., M.D.		22d. ADDRESS Prof. Bldg., Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Washington National	23d. LOCATION (City or Town) (County) (State) Suitland Maryland
24. FUNERAL DIRECTOR W.W. Chambers		25a. REC'D BY REGISTRAR Silver Spring Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 25 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07081

07062

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt Ranier			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greenbelt Convalesant Center				d. STREET ADDRESS 3406 Newton St. Apt. 3			
3. NAME OF DECEASED (Type or print) First Bessie Middle Louise Last Engel				4. DATE OF DEATH Month May Day 10 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1891	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Snow				14. MOTHER'S MAIDEN NAME Anna C. Burriss			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Evelyn Greene		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lung DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 months 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-12, 1964 to 5-10, 1967 , that (I) (we) last saw the deceased alive on 5-8, 1967 , and that death occurred at 12 PM , from the causes and on the date stated above.							
22a. SIGNATURE Donald C. Edgren				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN	
22d. ADDRESS 3500 East West Highway Hyattsville, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home. Washington, D. C.				25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

4/10/55

18081

2-11-55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07082

CERTIFICATE OF DEATH

07063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Madison Manor Nursing Home		d. STREET ADDRESS 5815 Swarthmore Drive	
3. NAME OF DECEASED (Type or print) Rachel (NMN) Evans		4. DATE OF DEATH Month May Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1870
9. AGE (in years last birthday) 97 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY England	
13. FATHER'S NAME James Wescott Smith		14. MOTHER'S MAIDEN NAME Rebecca ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220 4671062	
17. INFORMANT Mrs. Barbara Marx		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIO SCLEROSIS 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAR. 13, 1967 to MAY 30, 1967 , that (I) (we) last saw the deceased alive on MAY 30 1967 , and that death occurred at 11:35 PM , from causes and on the date stated above.			
22a. SIGNATURE J. E. Bowman M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED MAY 31, 1967
22c. PHYSICIAN'S NAME (Type) J. E. BOWMAN, M.D.		22d. ADDRESS 4021-18TH ST., N.E.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 5 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07083

07064

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
c. LENGTH OF STAY IN 1b minutes		d. STREET ADDRESS 12010 Maycheck Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penna R.R. Tracks, Zug Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marie B. Everett		4. DATE OF DEATH 5 3 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1924
9. AGE (In years last birthday) 42 yrs.		10. UNDER 1 YEAR 3 Months	11. UNDER 24 HRS. 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME-MAKER	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME ROY S. BRIDGES SR.		14. MOTHER'S MAIDEN NAME CALLIE E. BRIDGES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. BENJAMIN L. EVERETT	
17. INFORMANT (husband) Address Lane, Bowie, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 979X IMMEDIATE CAUSE (a) Total injuries DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Struck by Railroad train.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 5-3- 19 67 Hour a.m. 5:17pm p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Penna. R.R. Tracks, Zug Rd., Bowie, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 5-4-67	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 5/6/1967	23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia
24. FUNERAL DIRECTOR Hysong's Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 8 1967	

2004

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• 1991 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818 28

TABLE 1. *Continued*

1652-1653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07084 08560											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>						c. LENGTH OF STAY IN 1b <u>9 Mo.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12405 DELORAIN CIR.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WASHINGTON, DC - 161</u>					
d. STREET ADDRESS <u>12405 DELORAIN CIR</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>FRANCIS</u> Middle <u>FEENEY</u> Last						4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 23 1904</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POLICEMAN</u>				11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS F. FEENEY</u>						14. MOTHER'S MAIDEN NAME <u>ELIZABETH DOHERTY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>061-20-2658</u>		17. INFORMANT <u>AGNES FEENEY-WIFE ABOVE</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>612x</u> DUE TO <u>Chronic Pyelo-nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic Enlargement</u> (c) <u>Diabetes Mellitus & Proliferated Sanguine</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>4 years</u> <u>4 years</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>63</u> , to <u>May -31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 28</u> , 19 <u>67</u> , and that death occurred at <u>2:40</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>E. Stuart Lyddand</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddand, M. D.</u>						22d. ADDRESS <u>3066 Que St. N. W. Wash, D. C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sts Peter & Paul Cem</u>		23d. LOCATION (City, town or county) (State) <u>Elmira, New York</u>			
24. FUNERAL DIRECTOR <u>Joseph Gallers Son's Inc. Wash, D. C.</u>						25a. REC'D BY REGISTRAR <u>JUN 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
BUREAU OF RECORDS AND STATISTICS
BUREAU OF DEATH

02082

Form with multiple sections and fields, mostly illegible due to fading and bleed-through. Visible text includes:

- NAME
- AGE
- SEX
- RACE
- DATE OF BIRTH
- DATE OF DEATH
- PLACE OF BIRTH
- PLACE OF DEATH
- CAUSE OF DEATH
- DIAGNOSIS
- DATE OF EXAMINATION
- SIGNATURE
- DATE

Vertical text on the right margin, likely a filing or processing stamp, mostly illegible.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07065

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 3909 Nicholson Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Forrest Middle F. Last Ferguson		4. DATE OF DEATH Month 5 Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1940
9. AGE (In years lost birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN F. FERGUSON		14. MOTHER'S MAIDEN NAME LAURA JACOBS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 153-30-6418	
17. INFORMANT DIANA FERGUSON		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication 8910 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inhaled carbon monoxide in garage at home.	
20c. TIME OF INJURY Month, Day, Year about 3:00pm 5-22-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work Garage	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 5-23-67	
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-29-1967	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD.		25a. REC'D BY REGISTRAR MAY 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07086		07066	
1. PLACE OF DEATH o. COUNTY Prince George's Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges' Hospital		d. STREET ADDRESS 8500 N. Hampshire Ave.	
3. NAME OF DECEASED (Type or print) First HARRY Middle FINKELSTEIN Last FINKELSTEIN		4. DATE OF DEATH Month May Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 68 yrs.
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAX FINKELSTEIN		14. MOTHER'S MAIDEN NAME JENNIE ----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife		Address 8500 N. Hampshire Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Hypertensive Heart Dis. DUE TO yr (c) Diabetes Mellitus DUE TO yr.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10 , 1966, to May 9 , 1967, that (I) (we) last saw the deceased alive on May 8 , 1967, and that death occurred at 10:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Isidore Shulman		22b. DATE SIGNED 5-10-67	
22c. PHYSICIAN'S NAME (Type) ISIDORE SHULMAN		22d. ADDRESS 915-19th St NW DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/67	
23c. NAME OF CEMETERY OR CREMATORY Old Montefiore Cem.		23d. LOCATION (City or Town) (County) (State) Queens, Long Island, N.Y.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR MAY 15 1967	
ADDRESS 3501-14th St. NW, Wash. DC		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Prince George, British Columbia

Prince George, British Columbia

Max T. Stein
1000 N. W. 10th Ave.
Seattle, Wash. 98107

Max T. Stein
1000 N. W. 10th Ave.
Seattle, Wash. 98107

Max T. Stein
1000 N. W. 10th Ave.
Seattle, Wash. 98107

Max T. Stein
1000 N. W. 10th Ave.
Seattle, Wash. 98107

Max T. Stein
1000 N. W. 10th Ave.
Seattle, Wash. 98107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07087

CERTIFICATE OF DEATH

07067

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3-1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 45 D Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) XXXX (Last) Middle (First) Finkelstein, - Morris		DATE OF DEATH Month Day Year May 19, 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/90	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 062-05-7436A		17. INFORMANT Address 45-D Ridge Rd. Esther Gerson, Daughter Greenbelt, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days yell	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his husband) attended the deceased from 1957 to May 19, 1967, that (I) (we) last saw the deceased alive on May 19, 1967, and that death occurred at 12:10 PM, from causes and on the date stated above.							
22a. SIGNATURE [Signature]				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIR. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. PM		22b. DATE SIGNED 5-19-67	
22c. PHYSICIAN'S NAME (Type) William C. Weintraub, M. D.				22d. ADDRESS Prof. Bldg. Greenbelt, Maryland			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-21-67		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Goldberg Funeral Home				25a. REC'D BY REGISTRAR DATE MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR AIS (4)
20M S-63

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CERTIFICATE OF DEATH

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Prostatectomy
performed 3/20/50
3/20/50
3/20/50

4/20/50 4/20/50

4/20/50 4/20/50

FOR STATE
HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07069

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Howard ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 13.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS RFD 1, Box 297		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First McLure Middle Lawrence Last Fisher				4. DATE OF DEATH Month 5 Day 3 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 April 1905		9. AGE (In years lost birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY U S Govt		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Fisher				14. MOTHER'S MAIDEN NAME Mary Ross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Grace Fisher Address Gumbort Rd Laurel Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 5-4-67			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-6-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION (City or Town) (County) (State) Glen Burnie Md.	
24. FUNERAL DIRECTOR Witt				25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Item #2c Film #G388 5/12/67 pc
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07090

07070

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 104 Woodlawn Ct.	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Thomas Florentine		4. DATE OF DEATH Month Day Year 5 2 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1897
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Florentine		14. MOTHER'S MAIDEN NAME Mary Christina Lombardo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 8-1918/12-1918 213-20-9975	
17. INFORMANT Mrs Mary E. Florentine, Temonium, Maryland		2203 Eastridge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 2 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 5-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 5, 1967	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, NATIONAL CEM.		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland		25a. RECEIVED BY REGISTRAR MAY 5 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07091

CERTIFICATE OF DEATH

07071

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY in 1b 19 Hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6802 - 23rd Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maud F. Fort				4. DATE OF DEATH Month Day Year May 24, 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/89		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry T. Roland				14. MOTHER'S MAIDEN NAME Frances S. Cameron			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-50-6238		17. INFORMANT Address 1080-Plum Dr. Mrs. Norma V. Niles - Crownsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Psychoneurosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspirin						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19____, to May 24, 19 67 , that (I) (we) last saw the deceased alive on May 24, 19 67 , and that death occurred at 3:10 P.M. from causes and on the date stated above.							
22a. SIGNATURE Leon Levitsky M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Leon Levitsky, M. D.				22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE MAY 29 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

2352

5414232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE					c. LENGTH OF STAY IN 1b 5 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS AFB					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORRESTVILLE					
					d. STREET ADDRESS 8303 Beltz Drive					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) EDWARD H. GALPERN					4. DATE OF DEATH Month MAY Day 7 Year 1967					
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Jun 1918		9. AGE (in years last birthday) 48 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USARMY				10b. KIND OF BUSINESS OR INDUSTRY USARMY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ISRAEL GALPERN					14. MOTHER'S MAIDEN NAME GOLDIA ABRAMSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES					16. SOCIAL SECURITY NO. 159-01-8356		17. INFORMANT WIFE Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEART FAILURE & ACUTE PULMONARY EDEMA DUE TO (c) MYOCARDIAL INFARCTION								INTERVAL BETWEEN ONSET AND DEATH 1 HR		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that the (this hospital) attended the deceased from 2 May , 19 67 , to 7 May , 19 67 , that he (we) last saw the deceased alive on 7 May 19 67 and that death occurred at 6:15M from the causes and on the date stated above.										
22a. SIGNATURE Richard J. Wisely					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED A.M.			
22c. PHYSICIAN'S NAME (Type) RICHARD J. WISELY, CAPT, USAF MC					22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/67		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR Bernard Danzansky & Sons St. Wash. DC					ADDRESS 3501-14th		25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07093

CERTIFICATE OF DEATH

07073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY in 1b 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4110 Warner Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type of print) First Middle Last Samuel Gandler				4. DATE OF DEATH Month Day Year May 8, 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/15/1895	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 518-10-8488A		17. INFORMANT MRS. ESTHER GANDLER		Address 4110 WARNER AVE. HYATTSTVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular shock 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myocardial Infarction DUE TO (c) Severe Atherosclerotic Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from April 7, 19 67 , to May 8, 19 67 , that (he) (we) last saw the deceased alive on May 8, 19 67 , and that death occurred at 9:50 AM from causes and on the date stated above.							
22a. SIGNATURE U. Hernandez				22b. DATE SIGNED May 8, 1967		22c. PHYSICIAN'S NAME (Type) U. Hernandez, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City or Town) (County) (State) Hyattsville, Prince Geo. Md.	
24. FUNERAL DIRECTOR Donald M. Stein				25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07096

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Reside in institution) <u>07096</u> a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORRESTVILLE</u>		c. LENGTH OF STAY IN 1b <u>39 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REGENT NURSING HOME</u>		d. STREET ADDRESS <u>5114 Valley Road</u>	
3. NAME OF DECEASED (Type or print) <u>DOROTHEA E. GARDELLA</u>		4. DATE OF DEATH <u>MAY 8 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR <u>16</u> Months <u>1</u> Days <u>16</u> Hours <u>16</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
14. FATHER'S NAME <u>John A. Sheil</u>		15. MOTHER'S MAIDEN NAME <u>Harriet J. Wands</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>5114 Valley Road S. E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Dis</u> DUE TO (c) <u>Chronic Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>5-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> , 19 <u>67</u> , and that death occurred at <u>10:17</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard Kutzner</u>		22b. DATE SIGNED <u>5-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD KUTZNER M.D.</u>		22d. ADDRESS <u>2645 Weyler Rd. S.E. Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-10-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR <u>Robert E. Welchen</u>		25. REC'D BY REGISTRAR <u>MAY 11 1967</u>	
26. ADDRESS <u>4398 S. Sully Rd. Sully Md.</u>		27. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

10092

CERTIFICATE OF DEATH

10092

INVESTIGATION REPORT

NAME: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF BIRTH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

REPORTED BY: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

LOCATION: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

TESTIMONY: [illegible]

CONCLUSION: [illegible]

RECOMMENDATION: [illegible]

APPROVAL: [illegible]

REVISION: [illegible]

FINAL: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07095

CERTIFICATE OF DEATH

07075

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7830 Valley Park Road				d. STREET ADDRESS 7830 Valley Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARION V GATES First Middle Last				4. DATE OF DEATH Month May Day 7 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1890		9. AGE (In years lost birthday) yrs. 77	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Finley				14. MOTHER'S MAIDEN NAME Loretta Burke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Sheila G. Shaffer 7830 Valley Park Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 65 , to 5/17 , 19 67 , that (I) (we) last saw the deceased alive on 4/22 , 19 67 , and that death occurred at 5:30 P M, from causes and on the date stated above.							
22a. SIGNATURE Charles Jones, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-67		23c. NAME OF CEMETERY OR CREMATORY Great Neck Cemetery		23d. LOCATION (City or Town) (County) (State) Onset Massachusetts	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home				ADDRESS 308 Suitland Suitland Maryland		25a. REC'D BY REGISTRAR MAY 11 1967	
				25b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7082

STATE OF NEW YORK

1900

IN SENATE, JANUARY 1, 1900.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY: JAMES B. LEECH, STATE PRINTER, 1900.

THE COMMISSIONERS OF THE LAND OFFICE HAVE THE HONOR TO ACKNOWLEDGE THE RECEIPT OF THE FOLLOWING:

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<div>Item 18 Film 389 5-29-67</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>07096</div> <div>07076</div>									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs			d. STREET ADDRESS 5211 - Colonial Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5211 - Colonial Drive					d. STREET ADDRESS 5211 - Colonial Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth A. Gibson					4. DATE OF DEATH Month May 19th 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6th, 1921		9. AGE (In years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Dunkirk, Indiana			12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Charles Racer					14. MOTHER'S MAIDEN NAME Mary Helen Rectinanus				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.		17. INFIRMANT Curtis A. Gibson (Husband)			Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Original site undetermined DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 to May 19, 1967 , that (I) (we) last saw the deceased alive on May 19, 1967 , and that death occurred at 2:30 P. from the causes and on the date stated above.									
22a. SIGNATURE David N. Robb					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 19, 1967		
22c. PHYSICIAN'S NAME (Type) David N. Robb					22d. ADDRESS 5116 - Middleton Lane, Camp Springs, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 22-1967		23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		23d. LOCATION (City, town or county) (State) Dunkirk, Indiana		
24. FUNERAL DIRECTOR Simmons Bros.					ADDRESS 1661- Good Hope RD. SE Wash. DC.		25a. REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

07086

Roth A. Giam

James A. Giam (Husband)

1919

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07097

CERTIFICATE OF DEATH

07077

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 14 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 14-V5 Ridge Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle F. Last Griggs		4. DATE OF DEATH Month May Day 13 , Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/29
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Griggs		10b. KIND OF BUSINESS OR INDUSTRY Meats	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Emmett R Griggs		14. MOTHER'S MAIDEN NAME Gertrude F Azbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 578 30 8824	
17. INFORMANT Betty Jane Griggs		Address Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) D. cinchona (Pneumonia) of liver 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ② Fracture 2-3 ribs cc DUE TO (c) ③ porta-caval shunt thrombosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 29 , 19 67 , to May 13 , 19 67 , that (I) (we) last saw the deceased alive on May 13 , 19 67 , and that death occurred at 10:30 AM from causes and on the date stated above.			
22a. SIGNATURE John H. Bayly		22b. DATE SIGNED May 13, 1967	
22c. PHYSICIAN'S NAME (Type) John H. Bayly, M.D.		22d. ADDRESS 1835 Eye St., N.W., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md		25a. REC'D BY REGISTRAR MAY 17 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03007

WASHINGTON FIELD

047000

TO DIRECTOR, FBI (100-374301) FROM WASH. FIELD (100-374301) 1P
SUBJECT: [Illegible]

RE WASH. FIELD TELETYPE TO BUREAU, APRIL 11, 1967.
[Illegible text]

[Illegible text]

[Illegible text]

JOHN A. [Illegible]
1000 Eye St., N.W., Washington, D.C.
[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07098

CERTIFICATE OF DEATH

07078

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSP. ANDREWS		d. STREET ADDRESS GENERAL DELIVERY	
3. NAME OF DECEASED (Type or print) JOHN J. GRIMES		4. DATE OF DEATH Month MAY Day 14 Year 1967	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 AUG 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAJOR USA RETIRED		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) ROCHESTER NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOMER GRIMES		14. MOTHER'S MAIDEN NAME SALLY (Unkown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1917-1946		16. SOCIAL SECURITY NO. 214-28-4270	
17. INFORMANT ESTELLE W. GRIMES -WIFE-Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Ruptured Abd. Aortic Aneurysm		INTERVAL BETWEEN ONSET AND DEATH 10 years 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 May , 1967, to 14 May , 1967, that (I) (we) last saw the deceased alive on 14 May , 1967, and that death occurred at 0130 AM , from causes and on the date stated above.			
22a. SIGNATURE John Bristow		22b. DATE SIGNED 14 May '67	
22c. PHYSICIAN'S NAME (Type) JOHN W. BRISTOW CAPT, USAF, MC		22d. ADDRESS USAF HOSP. ANDREWS ANDREWS AFB, WASHINGTON, DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/17/1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. -La Plata, Md		25a. REC'D BY REGISTRAR MAY 19 1967	
25b. REGISTRAR'S SIGNATURE J. J. Judge			

440

THE STATE OF TEXAS

1903

IN SENATE,
January 13, 1903.

REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1902.

THE COMMISSIONER OF THE LAND OFFICE,
HON. J. W. WALKER,
LAND OFFICE,
DAVIS BUILDING,
HOUSTON, TEXAS.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07093

CERTIFICATE OF DEATH

07079

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base				c. LENGTH OF STAY IN 1b 8 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				d. STREET ADDRESS 6219 Nottingham Drive			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBIN RENEE GROSS				4. DATE OF DEATH Month MAY Day 13 Year 1967			
5. SEX FEMALE		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1967	
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 8 Days 8 Hours 19 Min.		11. BIRTHPLACE (County & State, or foreign country) Andrews A.F.B. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -			
13. FATHER'S NAME Leonard Paul Price				14. MOTHER'S MAIDEN NAME (Never Married) JOAN MAUREEN GROSS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. -		17. INFORMANT Mother 6219 Nottingham Drive Camp Springs, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7545 IMMEDIATE CAUSE (a) Congenital Heart Disease DUE TO (b) 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1967 to May 13, 1967 , that (I) (we) last saw the deceased alive on May 13, 1967 , and that death occurred at 7 PM , from causes and on the date stated above.							
22a. SIGNATURE Phillip Steiner				22b. DATE SIGNED May 13, 1967			
22c. PHYSICIAN'S NAME (Type) PHILLIP STEINER, CAPT, USAF, MC				22d. ADDRESS USAF HOSP. ANDREWS Wash. D.C. 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-15-67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL Cemetery		23d. LOCATION (City or Town) (County) (State) PRINCE GEORGE MD	
24. FUNERAL DIRECTOR Robert E. Wickham F. Howe				25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02039

1955

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07:00

07080

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS 4115 Rainier Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital							
3. NAME OF DECEASED (Type or print) First Middle Last Belle Young Haut				4. DATE OF DEATH Month Day Year 5 4 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-1908	
9. AGE (In years lost birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME FRED O YOUNG		14. MOTHER'S MAIDEN NAME ELLA WESSER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579305135		17. INFORMANT MRS. BETTY-JO SIEVERT Address 5106 KENILWORTH AV EDMONSTON, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute thrombotic occlusion of right and left anterior, descending branches (b) And Myocardial infarction, posterior wall (c) From Stenosing coronary arteriosclerosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Due to							INTERVAL BETWEEN ONSET AND DEATH minutes days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. M.D.				22. DATE SIGNED 5-5-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-8-1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD ADDRESS				25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

07100

Prince George

1911

1911

British Columbia

June 1911

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07101

CERTIFICATE OF DEATH

07081

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 3721 18th St., N.E.	
3. NAME OF DECEASED (Type or print) First Bessie Middle L. Last Henighan		4. DATE OF DEATH Month May Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1916
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Austin Henighan		14. MOTHER'S MAIDEN NAME Janie Houston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-20-0526	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 2890 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Malignant histiocytosis		INTERVAL BETWEEN ONSET AND DEATH 7 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis 0021		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 2-24 , 19 67 , to 5-12 , 19 67 , that (H) (we) last saw the deceased alive on 5/12 , 19 67 , and that death occurred 06:00A.M. from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 5/12/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL/CREMATION, REMOVAL (Specify) 5-15-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Charlotte, N.C.	
24. FUNERAL DIRECTOR Arazeis Funeral Home		25a. REC'D BY REGISTRAR MAY 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1992

50150

2524

[Faint handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Deputy Med. Exam. Notified (Dr. John Kehoe) & approved.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #14 & 14 Film #G389 5/23/67 pc

07102

CERTIFICATE OF DEATH

07082

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Pro Geo Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b D O A	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 7915 Legation Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle H Last Hess		4. DATE OF DEATH Month May 12, 1967 Day 19 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 27, 1900
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Maris Hoskins		14. MOTHER'S MAIDEN NAME Victoria Derby Daily	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W W II		16. SOCIAL SECURITY NO. 577 30 7535	
17. INFORMANT Steen Donald H Hess		Address New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiac Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/26, 1957, to May 2, 1967, that (I) (we) last saw the deceased alive on May 2, 1967, and that death occurred at 4:05 PM, from causes and on the date stated above.			
22a. SIGNATURE Gordon W Kelley		22b. DATE SIGNED May 12-1967	
22c. PHYSICIAN'S NAME (Type) Gordon W Kelley		22d. ADDRESS 6124 41th ave Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

01010

01010

RECEIVED MAY 10 1967

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter body with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

DATE: MAY 10 1967
BY: [Illegible]
[Illegible text at the bottom of the page, possibly a signature or distribution list.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07083

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4909 66th. Ave.	
3. NAME OF DECEASED (Type or print) First Alfred Middle Moore Last Hicks		4. DATE OF DEATH Month 5 Day 19 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 June 1924
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallie O. Hicks		14. MOTHER'S MAIDEN NAME Lena F. Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Benjamin A. Posey		Address 4813 67th Ave. Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and hemorrhage 5811 DUE TO Rupture of oesophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) From portal hypertension DUE TO From Cirrhosis of liver (c) From Chronic alcoholism		INTERVAL BETWEEN ONSET AND DEATH minutes minutes months years 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/22/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md	
24. FUNERAL DIRECTOR The S.H. Hines Company		25a. REGISTRAR'S SIGNATURE Charles Judge	
2901 14th St. N.W. Washington, D.C.		DATE MAY 22 1967	

60152

— 952 —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE SIGNED WITH PERMISSION OF
DR. KEHDE - ASST. MED. EXAMINER

MEDICAL CERTIFICATION

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07104

CERTIFICATE OF DEATH

07084

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN 1b <u>13 YRS.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7629 CHRIS-MAR AVE</u>				d. STREET ADDRESS <u>CLINTON, 16.1</u>			
3. NAME OF DECEASED (Type or print) <u>JAMES A HILL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 11, 1928</u>	
9. AGE (In years lost birthday) <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHAS. CO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK C. HILL</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE BUCKLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-22-2407</u>		17. INFORMANT <u>WIFE</u>		Address <u>7629 CHRIS-MAR AVE-CLINTON</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CARDIAC ARREST</u> DUE TO <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC-CARDIOVASCULAR DISEASE-WITH HEALED MYOCARDIAL INFARCTION</u> DUE TO <u>1 YEAR</u> (c) <u>NONE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>10 MIN.</u> <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour, a.m. <u>NONE</u> p.m. <u>NONE</u>		20d. INJURY OCCURRED While <u>NONE</u> at work <u>NONE</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.) <u>NONE</u>		20f. (City or town) (County) (State) <u>NONE</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 25, 1966</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>APRIL 22, 1967</u> , and that death occurred at <u>4:54 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Shaver Jr.</u>				22b. DATE SIGNED <u>May 2, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>	
22d. ADDRESS <u>8808 OLD BRANCH AVE. CLINTON MD</u>				22e. REC'D BY REGISTRAR <u>MAY 5 1967</u>		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 6th 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>				24a. ADDRESS <u>1661-Good Hope Rd SE Wash DC</u>		24b. DATE <u>MAY 5 1967</u>	

2050

4400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #13 Film #G389 6/5/67 PC

07105

CERTIFICATE OF DEATH

07085

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Roy R. Hiner				4. DATE OF DEATH Month Day Year May 24, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Oct. 1930	
9. AGE (In years lost birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, then if retired) Truck Driver		11. BIRTHPLACE (County & State, or foreign country) Takoma Park		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Hiner				14. MOTHER'S MAIDEN NAME Virginia Beck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 254 6412		17. INFORMANT Raymond S. Hiner Address 203 Monroe	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic FAILURE 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Encephalitis of LIVER DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (s) (this hospital) attended the deceased from May 16, 1967 , to May 24, 1967 , that (s) (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 6:45 AM , from causes and on the date stated above.			
22a. SIGNATURE W. Hernandez				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) T. J. HERNANDEZ, MD	
22d. ADDRESS Prince Georges General Hospital				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF May 26-1967				23c. NAME OF CEMETERY OR CREMATORY Lack Creek			
23d. LOCATION (City or Town) (County) (State) Washington DC				24. FUNERAL DIRECTOR Charles Judge			
25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE MAY 29 1967							

07102

Mr. J. B. Tooten

Chicago, Ill.

Prince George's General Hospital

Box

N.

Winnipeg

Man.

Can.

White

18 Oct. 1930

To

Mr. J. B.

Dr.

Oct. 22, 1930

07

May 18,

Dr. J. B. Tooten (General Hospital)

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07086

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Cheverly		c. LENGTH OF STAY IN 1b D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.	
3. NAME OF DECEASED (Type or print) Ruth Land Hoke		4. DATE OF DEATH Month May Day 6 Year 19 67.	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 24, 1908
9. AGE (In years and birthdate) 58 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 67.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10b. KIND OF BUSINESS OR INDUSTRY Interior Decorator	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Land		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 578 28 8651	
17. INFORMANT Robert Hoke		Address Bladensburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive cardio vascular disease DUE TO (c) Unknown		INTERVAL BETWEEN DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		22. DATE SIGNED 5-7-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Stanley Cemetery		23d. LOCATION (City or Town) (County) (State) Stanley Gaston N. C.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

3050

[illegible]

142

Subsidiary Information

CONCLUSIONS

1991

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

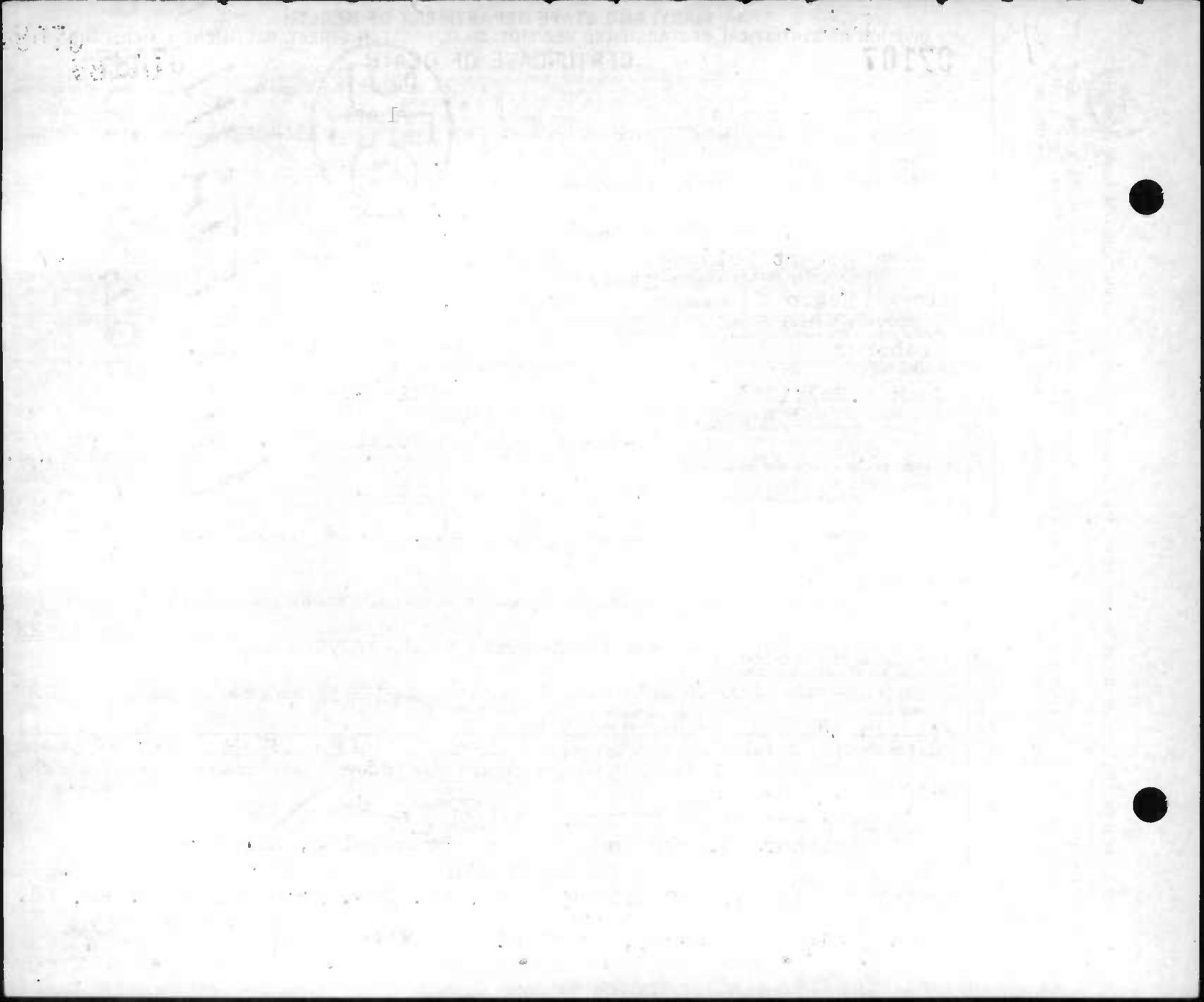
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07107

CERTIFICATE OF DEATH

07087

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> 161			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>Rt. 10 Box 435</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Briscoe</u> First <u>Holiday</u> Middle Last				4. DATE OF DEATH <u>May</u> 18 1967 Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1911</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Prince George Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John L. Holliday</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Green lief</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-12-7694</u>		17. INFORMANT Address <u>Milton Holliday Rt. 1-Box 435 Brandywine Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diagnosed Cor. Artery Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-18</u> 19 <u>67</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Dobs on</u>				22b. DATE SIGNED <u>MAY 24 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobs on</u> ADDRESS <u>Brandywine, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gibbons Meth. Ch. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Brandywine Pr. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>Martell Adams</u> ADDRESS <u>Aquasco, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAY 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07108

CERTIFICATE OF DEATH

07088

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			d. STREET ADDRESS 3540 MADONA LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOYCE Middle T. Last HOPPE			4. DATE OF DEATH Month MAY Day 11 Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 JUN 35		9. AGE (In years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) BIRMINGHAM, ALABAMA	
13. FATHER'S NAME S.E. Thompson			14. MOTHER'S MAIDEN NAME LILLIAN HORSLEY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Capt. Louis A. Hoppe HUSBAND Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 RENAL AND HEPATIC FAILURE DUE TO (b) METASTATIC CARCINOMA DUE TO (c) ADENOCARCINOMA OF COLON					INTERVAL BETWEEN ONSET AND DEATH 1 Month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from 6 April, 19 67 to 11 May, 1967, that the (we) last saw the deceased alive on 11 May 1967, and that death occurred at 0:25M from causes on and on the date stated above. A.M.					
22a. SIGNATURE Warren E. Johnson			22b. DATE SIGNED 11 May 1967		22c. PHYSICIAN'S NAME (Type) WARREN E. JOHNSON, CAPT, USAF MC
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF May 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery Cincinnati Hamilton Ohio	
24. FUNERAL DIRECTOR Beverly E. Hopping Hopping Funeral Home - Annapolis, Maryland			25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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DEPARTMENT OF AGRICULTURE

30170

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07109

CERTIFICATE OF DEATH

07089

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>14 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PRINCE GEORGES' GENERAL Hosp.</u>		d. STREET ADDRESS <u>2302 BERKLEY ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>J.</u> Last <u>HOWARD</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>87</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennd. R.B.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Joseph Howard</u>		14. MOTHER'S MAIDEN NAME <u>Susan Ella Jennings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>RESSER L. HOWARD</u>		Address <u>1411 Florida AVE Woodbridge, VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lungs</u> 103X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>103X</u> (c) <u>103X</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/6</u> , 19 <u>67</u> , to <u>5/20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Hermandy no</u>		22b. DATE SIGNED <u>5/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. J. Hernandez MD</u>		22d. ADDRESS <u>PGG II</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Birchwood Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>ROXBORO. N.C.</u>
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME 3004 1ST ST</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 25 1967</u>			

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STATE OF TEXAS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07090

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 25-G Ridge Road	
3. NAME OF DECEASED (Type or print) First Middle Last Marvin John Huffman		4. DATE OF DEATH Month Day Year 5 28 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-38
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10b. KIND OF BUSINESS OR AMERICAN IRON WORKS	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RALEIGH R. HUFFMAN		14. MOTHER'S MAIDEN NAME RETA BISHOP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-36-2619	
17. INFORMANT Dorothy L. Huffman Address Wife Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-arachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rupture of aneurysm of circle of Willis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH MINUTES			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 5-28-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-31-67	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN	23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND
24. FUNERAL DIRECTOR GASCH'S ADDRESS 4739 Baltimore Ave. Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 31 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07111

CERTIFICATE OF DEATH

07091

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5104 72nd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle (Humphries) Last Humphreys				4. DATE OF DEATH Month May Day 5 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/80		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) D C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel H. Atwell				14. MOTHER'S MAIDEN NAME Sarah E. Cole			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Robert C. Humphried same as # 2.D			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ABDOMINAL Tumor						INTERVAL BETWEEN ONSET AND DEATH 32 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 57 to May 5 , 19 67 , that (I) (we) last saw the deceased alive on 5-5 19 67 , and that death occurred at 10:15 PM from causes and on the date stated above.							
22a. SIGNATURE Albert Roth				22b. DATE SIGNED 5-5-67		22c. PHYSICIAN'S NAME (Type) Albert Roth, M. D.	
22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5.9.67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland. Maryland	
24. FUNERAL DIRECTOR Lee Funeral Home, Wash D.C.				25a. REC'D BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07117

George George's

Chesley

Prince George's General Hospital

Catholics

Female White

Donnell

Donnell E. Donnell

HC

CERTIFICATE OF DEATH

W. Mayland

Westerville

St. John's Church

(Husband)

W. 17/80

Donnell E. Donnell

07117

Prince George's

2408 Riverdale St., Riverdale, Mo.

Albert Horn, H. D.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 18, Film G388 5/19/67, csc

07112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07092

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 5287 Marlboro Pike	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Deborah Middle Lynn Last Jewell		4. DATE OF DEATH Month 5 Day 2 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Jan. 1967
9. AGE (In years lost birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 16 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		11b. KIND OF BUSINESS OR INDUSTRY ---	
12. BIRTHPLACE (State or foreign country) MARYLAND		13. CITIZEN OF WHAT COUNTRY? ---	
14. FATHER'S NAME DONALD E JEWELL		15. MOTHER'S MAIDEN NAME ALICE CALLISON	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		17. SOCIAL SECURITY NO. NONE	
18. INFORMANT DONALD E JEWELL		Address SAME AS 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492x PNEUMONITIS DUE TO (b) (SDII) Due to Diplococcus pneumoniae DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 5-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 5-5-67	23c. NAME OF CEMETERY OR CREMATORY HOLLEY CEMETERY	23d. LOCATION (City or Town) (County) (State) HOLLEY NEW YORK
24. FUNERAL DIRECTOR W. Chambers		25a. REC'D BY REGISTRAR MAY 5 1967	
Address 517-11th ST SE Wash, DC.		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07113

CERTIFICATE OF DEATH

07093

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS R. F. D. # 172		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George ^{First} B. ^{Middle} Johnson Sr. ^{Last}				4. DATE OF DEATH May ^{Month} 2, ^{Day} 19 ^{Year} 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 6, 1904	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Johnson				14. MOTHER'S MAIDEN NAME Adeline McCoy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 216 46 0371		17. INFORMANT May E. Johnson 414 Brightseat Road Lanham, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) White Coronary Thrombus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1967 to Jan 3, 1967 , that (I) (we) last saw the deceased alive on Jan 2, 1967 , and that death occurred at 2:18 P.M. from causes and on the date stated above.							
22a. SIGNATURE Aaron Deitz				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-367	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.				22d. ADDRESS Prince George Plaza Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07114			CERTIFICATE OF DEATH			07094			
1. PLACE OF DEATH a. COUNTY Prince Georges			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier Riverdale			c. LENGTH OF STAY IN 1b 1 day			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial			d. STREET ADDRESS 4100 - 30th Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Loraine			First Middle Last Ruby Johnson			4. DATE OF DEATH Month Day Year 5- 6 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-20		9. AGE (In years last birthday) yrs. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Jeff Moore				14. MOTHER'S MAIDEN NAME Minnie Susan Adams					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 277-24-7728		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5870 ACUTE PANCREATITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEMORRHAGIC GASTRITIS, LIVER FAILURE OBESITY						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-6, 19 67, to 5-7, 19 67, that (I) (we) last saw the deceased alive on 5-7 19 67, and that death occurred at 11:45 A.M. from causes and on the date stated above.									
22a. SIGNATURE C. J. Houmann		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-7-67					
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/67		23c. NAME OF CEMETERY OR CREMATORY East Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Valley's Funeral Home		ADDRESS MT RAINIER		25a. REC'D BY REGISTRAR DATE MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
07115					CERTIFICATE OF DEATH					07095					
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ANDREWS AIR FORCE BASE HOSPITAL					d. STREET ADDRESS 5205 COLUMBIA TERRACE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD RICHARD JONES					4. DATE OF DEATH Month Day Year MAY 20 1967										
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 JULY 1899		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION				11. BIRTHPLACE (County & State, or foreign country) MASSACHUSETTS				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HARRY JONES					14. MOTHER'S MAIDEN NAME CHARLOTTE MALONE										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 008 03 4210					17. INFORMANT Address MARIE V. JONES CAMP SPRINGS, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 12-4, 1966 to 5-20, 1967 , that (I) (we) last saw the deceased alive on 5-16-67 , and that death occurred at 2230 M, from the causes and on the date stated above.															
22a. SIGNATURE Frederick L. Sachs M.D.					22b. DATE SIGNED 5-21-67										
22c. PHYSICIAN'S NAME (Type) FREDERICK L. SACHS					22d. ADDRESS ANDREWS AIR FORCE BASE HOSP.										
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b. DATE THEREOF 5/21/67		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN			23d. LOCATION (City, town or county) (State) BLADENSBURG, MD.							
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC.					25a. REC'D BY REGISTRAR WASH. D.C.					25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07116

07096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>2 months 11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Pineview Gardens Health Care Center</u>		d. STREET ADDRESS <u>Box 4612</u>	
3. NAME OF DECEASED (Type or print) First <u>ALTA</u> Middle <u>TOL</u> Last <u>JOWETT</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH <u>1-15-1989</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PRINCE GEORGES, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLINTON BEALL</u>		14. MOTHER'S MAIDEN NAME <u>MARY DUCKETT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. WILTON T. JOWETT</u>		Address <u>Box 4612 Upper Marlboro, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>2-28</u> , 19 <u>67</u> , to <u>5-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>67</u> , and that death occurred at <u>1:55 PM</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD</u>		22d. ADDRESS <u>Clinton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Croom Md.</u>
24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>		25. REC'D BY REGISTRAR DATE <u>MAY 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10/10/67

10/10/67

CENTRAL OF DEATH

10/10/67

10/10/67

10/10/67

Clinton, Maryland

10/10/67

10/10/67

10/10/67

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117		07097	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 1300 44th. Pl., S.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marion H. Kagey		4. DATE OF DEATH Month Day Year 5 3 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gabriel Morrison		14. MOTHER'S MAIDEN NAME McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Samuel W. Kagey		Address same as D.2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 5-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5.6.67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Maryland
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25a. REC'D BY REGISTRAR MAY 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Director of Customs

San Francisco

San Francisco, Cal.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07118

07098

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b 11 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 9033 48th. Place		
3. NAME OF DECEASED (Type or print) First Aubrey Middle J. Last Kendall			4. DATE OF DEATH Month 5 Day 29 Year 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Jan. 1909		9. AGE (In years last birthday) yrs. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Clerk U.S.G.			10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Jausha Wilder Kendall			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Irene Connors			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 578-05-2978			17. INFORMANT Address Mrs. Rachel D. Kendall (above address)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head in bedroom of home.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:15am p.m. 5-18- 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) same as #2	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		22. DATE SIGNED 5-30-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION (City or Town) Suitland, Md.	(County)	(State)
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			25a. REC'D BY REGISTRAR DATE JUN 5 1967		
ADDRESS Mt. Rainier Maryland			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07119

07099

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE, MD c. LENGTH OF STAY IN 1b 16.1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 715 DENNIS STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PATRICIA L KENNEDY				4. DATE OF DEATH Month MAY Day 27 Year 1967			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 11, 1935	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months 16 Days 1		IF UNDER 24 HRS. Hours 19 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY BANGOR, MAINE		11. BIRTHPLACE (County & State, or foreign country) UNITED STATES	
13. FATHER'S NAME CLARENCE A. CLUKEY				14. MOTHER'S MAIDEN NAME FLORENCE A. GAGNON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT W.H. KENNEDY, 3815-4 LOUISANNA AVE. BASE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CARCINOMATOSIS 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CARCINOMA, EPIDERMAL, UTERINE CERVIX (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 15 MAY 67 , 19 67 , to 27 MAY , 19 67 that (I) XXX last saw the deceased alive on 27 MAY , 19 67 , and that death occurred at 0423 , from the causes and on the date stated above.							
22a. SIGNATURE <i>Michael L Jordan</i> 22c. PHYSICIAN'S NAME (Type) MICHAEL L JORDAN, CAPT USAF MC				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS USAFH ANDREWS AIR FORCE BASE, MD		22b. DATE SIGNED 27 MAY 67	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1327-121		23b. DATE THEREOF 5/30/67		23c. NAME OF CEMETERY OR CREMATORY BANGOR MAINE		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W.H. Chambers Co Washington DC</i>				ADDRESS 517-11 4th St SE Washington DC		25a. REC'D BY REGISTRAR JUN 1 1967	
				25b. REGISTRAR'S SIGNATURE <i>Juanita Judge</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07120		07100	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 3851 St. Barnabas Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle H Last Kidd		4. DATE OF DEATH Month 5 Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-1897
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Kidd		14. MOTHER'S MAIDEN NAME Georgie Windsor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Alba L. Kidd	
17. INFORMANT Same As # 2		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 5-25-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/27/67	23c. NAME OF CEMETERY OR CREMATORY Washington National	23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR MAY 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07121

CERTIFICATE OF DEATH

07101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY in 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>400 - 64th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>B</u> Last <u>Knight</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 May 1882</u>	9. AGE (In years last birthday) <u>84</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Heflin</u>				14. MOTHER'S MAIDEN NAME <u>Sarah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>579-16-5784</u>		17. INFORMANT <u>Mrs Lee Thompson</u> <u>Capitol Hgts. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from <u>April 30,</u> 19 <u>67</u> , to <u>May 2,</u> 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>May 2,</u> 19 <u>67</u> , and that death occurred at <u>12.07AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Tomas Hernandez</u>				22b. DATE SIGNED <u>5/2/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Tomas Hernandez</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/5/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, Maryland.</u>		
24. FUNERAL DIRECTOR <u>W.W. Chambers & Revueval Inc</u>				25a. REC'D BY REGISTRAR <u>MAY 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

CERTIFICATE OF DEATH

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
BURIAL	MAY 12, 1967	WASHINGTON NATIONAL	SCITLAND, MARYLAND	
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS Co	RIVERDALE, MD		MAY 15 1967	Charles Judge
			DATE	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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07103

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY E RIE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 122 Rice Ave.			
3. NAME OF DECEASED (Type or print) First Arthur Middle M. Last Kunz JR.				4. DATE OF DEATH Month 5 Day 11 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1946		9. AGE (In years last birthday) 20 yrs.	10. IF UNDER 1 YEAR Months 0 Days 11 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY STUDENT		11. BIRTHPLACE (State or foreign country) ERIE, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ARTHUR M. KUNZ, SR.				14. MOTHER'S MAIDEN NAME MABEL HOLIDAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (FRIEND) Address R. VAN VLIET 12520 EASTBOURNE DRIVE, SILVER SPRING MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 9364 DUE TO Status post operative repair of laceration of liver. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collided with other baseball player					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30pm 5-8-67 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Base ball field, Univ. Of Md., College Park		20f. (City or town) (County) (State) Prince George Co.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 5-12-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/15/1967		23c. NAME OF CEMETERY OR CREMATORY GIRARD, PENNSYLVANIA		23d. LOCATION (City or town) (County) (State) WASH. D.C.	
24. FUNERAL DIRECTOR HYSONG'S FUNERAL HOME		25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 1390 N. STREET, N.W.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07124					07104				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Prince Georges MARYLAND					a. STATE Washington, D. C. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital					d. STREET ADDRESS 500 0 St., N. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
James H. Lawson						5 6 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/23/1901		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY last employed-Ft. Belvoir		11. BIRTHPLACE (County & State, or foreign country) Spottsylvania, Va.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmore Lawson					14. MOTHER'S MAIDEN NAME Cora Stanley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 726-12-1772		17. INFORMANT Decedent Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis with atherosclerotic heart disease; diabetes mellitus; bilateral above-knee amputations, right 1/62, left 1/64.								INTERVAL BETWEEN ONSET AND DEATH 12 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (a) (this hospital) attended the deceased from 5/4/ , 19 56 , to 5/6/ , 19 67 , that (a) (we) last saw the deceased alive on 5/6/ 1967 , and that death occurred at 12 noon from causes and on the date stated above.									
22a. SIGNATURE Moe Weiss					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/6/67		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.				
23a. BURIAL/CREMATION, REMOVAL (Specify) 5/10/67			23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial			23d. LOCATION (City or Town) (County) (State) Landover, Md.			
24. FUNERAL DIRECTOR Frederick F. H. 389 R. d. ave. n.w.					25a. REC'D BY REGISTRAR DATE MAY 12 1967		25b. REGISTRAR'S SIGNATURE Charles Jones		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07105

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b 31 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melvin Middle L. Last (Sr.)Leizear		4. DATE OF DEATH Month May Day 20 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/06
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 12 Days 11	11. IF UNDER 24 HRS. Hours 16 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert B. Lizear		14. MOTHER'S MAIDEN NAME Daisey E. Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 10 8996	
17. INFORMANT Gertrude E. Leizear		Address Same as #2 (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Abscesses with Septicemia DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 19 , 19 67 , to May 20 , 19 67 , that (I) (we) last saw the deceased alive on May 20 , 19 67 , and that death occurred at 7:55 M. from causes on and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED 5/20/67	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Hyattsville, Maryland Francis Gasch's Sons		25a. REC'D BY REGISTRAR MAY 22 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Princess George's

Princess George's

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Princess George's Hospital

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Princess George's Hospital

Princess George's Hospital

Princess George's Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07126

07106

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Heights Estate</u>		c. LENGTH OF STAY IN 1b <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Heights Estate 16-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3907 Commander Drive</u>				d. STREET ADDRESS <u>3907 Commander Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kate Day Lewis</u> First Middle Last				4. DATE OF DEATH <u>May 13</u> 19 <u>67</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Sept 1869</u> yrs. Months Days Min.	9. AGE (In years last birthday) <u>97</u> yrs. Months Days Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Shannon Co Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Bledsoe Day</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Moore Day</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-54-2386</u>		17. INFORMANT <u>Katherine Day</u> Address <u>3907 Commander Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4330</u> DUE TO <u>Progressive neurocirculatory failure</u> DUE TO <u>generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u> </u> , to <u>13 May</u> , 19 <u>67</u> , that (I) <u>two</u> last saw the deceased alive on <u>12 May</u> , 19 <u>67</u> , and that death occurred at <u>4a</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Mattingly M.D.</u>				22b. DATE SIGNED <u>13 May 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Mattingly M.D.</u>				22d. ADDRESS <u>2200 R. Lane N.E. D.C. 20018</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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DEPARTMENT OF COMMERCE

[Faint, illegible text, likely bleed-through from the reverse side of the page]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07127

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07107

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN ID DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. Geo. General		e. STREET ADDRESS 5510 18th St. NW, Wash. D.C.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ALLEN LEWIS		4. DATE OF DEATH May 20 19 47	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 10 1915 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Govt	
11. BIRTHPLACE (State or foreign country) Formfield NC		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Benjamin Lewis		14. MOTHER'S MAIDEN NAME Dora Grody	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-0396	
17. INFORMANT Address 5008 Siltwater Hill Rd. S.W. Wash. D.C. Matty Renner		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO (b) Arteriosclerotic Heart Disease 10 years DUE TO (c) Hypertensive Cordis vasculor disease 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayt O WATKINS		22. DATE SIGNED 5-21-47	
EXAMINER'S NAME (Type) DAYTON O WATKINS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23, 1967	
23c. NAME OF CEMETERY OR CREMATORY Valley View		23d. LOCATION (City, town or county) (State) Notkewille, Virginia	
24. FUNERAL DIRECTOR Ches Funeral Home		25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE MAY 23 1967	

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James H. May 23, 1967
2887 Wilson Road
Washington, DC

Washington, Virginia

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film 0389 5/25/67 kk

07128

CERTIFICATE OF DEATH

07108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Lauderdale</u>		483	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Regent Nrs. + Rehabilitation Center</u>				d. STREET ADDRESS <u>639 Middle River Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alexander</u> First <u>Licariene</u> Middle Last				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1888</u>	9. AGE (In years lost birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u> Hours <u>6</u> Min.		11. IF UNDER 24 HRS. Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Navy Yard</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacinto Licariene</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Glass</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-64-6487</u>		17. INFORMANT <u>Hyson Licariene 7411 Lacey St. Bethesda, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Liver & Colon</u> DUE TO (c) <u>5-20-67</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-20-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1-3-</u> <u>1967</u> to <u>5-20</u> <u>1967</u> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>5-20-67</u> <u>19</u> , and that death occurred <u>1150 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Mark H. Pillor MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>5-20-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Mark H. Pillor MD</u>				22d. ADDRESS <u>6400 Marlboro Pike SE Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/24/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat'l</u>		23d. LOCATION (City or Town) (County) (State) <u>Switzland, Md</u>	
24. FUNERAL DIRECTOR <u>Maloney 131-11th St. SE D.C.</u>				25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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1/24/40

Dear Mr. [illegible]

Enclosed please find [illegible]

Very truly yours,

2-13-40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07123

CERTIFICATE OF DEATH

07109

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 16 hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7405 Tilden St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Doris M. Lilly				4. DATE OF DEATH Month Day Year May 16 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/20/29		9. AGE (In years lost birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank A Werner				14. MOTHER'S MAIDEN NAME Martha D Hicks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Clarence B Lilly Address Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scleroderma 7100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							INTERVAL BETWEEN ONSET AND DEATH 6 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) this hospital attended the deceased from June , 19 56 , to May 16 , 19 67 , that (I) was saw the deceased alive on May 16 , 19 67 , and that death occurred at 9 A.M. from causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE William D. Rosson				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William D. Rosson, M. D.				22d. ADDRESS 5701 - 85th Ave. Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville Md.				25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07130

CERTIFICATE OF DEATH

07110

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alice L Lohr		4. DATE OF DEATH Month Day Year May 16 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Feb., 1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FRANK E. PYWELL		14. MOTHER'S MAIDEN NAME LOUISE WEITZEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ARTHUR J. LOHR		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from May 7, 1967 , to May 16, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 1:50 PM from causes and on the date stated above.			
22a. SIGNATURE Donald W. Mitchell		22b. DATE SIGNED 5/17/67	
22c. PHYSICIAN'S NAME (Type) Donald W. Mitchell, M.D.		22d. ADDRESS 1746 K ST NW WASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-20-1967	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR W.W. Chambers		25. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 22 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G389 6/6/67 pc

07131

CERTIFICATE OF DEATH

07111

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 1139 49th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Alvin Last Long			4. DATE OF DEATH Month May Day 19 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1916		9. AGE (In years last birthday) 50 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painter		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Fred L. Long			14. MOTHER'S MAIDEN NAME Susie P. Waller		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 18		17. INFORMANT John M. Long 1130 49th. Ave. Hillside Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bacterial endocarditis aortic valve 4300 DUE TO with perforation of aortic cusp. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral bronchial pneumonia, severe. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 17 , 19 67 , to May 19 , 19 67 , that (I) (we) last saw the deceased alive on May 19 , 19 67 , and that death occurred at 4:05 M. from causes and on the date stated above.					
22a. SIGNATURE Edwin J. Jensen			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 20, 1967
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.			22d. ADDRESS Prince George's General Hospital Cheverly, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Wash. National Cem.	
24. FUNERAL DIRECTOR Robert E. Wilhelm		ADDRESS Fun. Home 4308 Suitland Rd. Suitland, Md.		25a. REC'D BY REGISTRAR MAY 24 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

07131

CERTIFICATE OF DEATH

07131

Prince George's

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Prince George's

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1132 West Avenue

Prince George's General Hospital

John

John

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White

Male

Acute bacterial endocarditis, aortic valve
with perforation of aortic cusp.
Direct original specimen, positive.

May 17, 1967

May 19, 1967

1967

May 20, 1967
Prince George's General Hospital
County, Maryland

Paula J. Hanson, M.D.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07132

07112

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 7615 Gateway Blvd.			
3. NAME OF DECEASED (Type or print) First Mamie Middle J. Last Mack			4. DATE OF DEATH Month 5 Day 23 Year 19 67				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Nov. 1890		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thaddues Alsop				14. MOTHER'S MAIDEN NAME Catherine Frank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Harold V. Mack Address Same As # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 443X DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH minutes over 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - over 5 years.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-24-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm				ADDRESS Funeral Home		25a. REC'D BY REGISTRAR MAY 29 1967	
4308 Suitland Road, Suitland, Maryland				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07113

FOR STATE
HEALTH DEPT.

07133

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 1688 Westphalia Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marion Madsen		4. DATE OF DEATH Month Day Year 5 29 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1896
9. AGE (In years lost birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min. 16 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Crist L. Madsen		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 5-31-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORY Washington National
23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland		25a. REC'D BY REGISTRAR DATE JUN 5 1967	
24. FUNERAL DIRECTOR Robert E. Wilhelm 4308 Suitland Road, Suitland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07134

CERTIFICATE OF DEATH

07114

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN Ib 9 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4929 Temple Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel ALFRED Marquis JR.				4. DATE OF DEATH Month Day Year May 4, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1907	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL A. MARQUIS				14. MOTHER'S MAIDEN NAME BERTHA LANLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address THELMA L. MARQUIS SAME AS # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 DUE TO Hepatic Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Portal DUE TO Cirrhosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 4x (this hospital) attended the deceased from April 25, 1967 , to May 4, 1967 , that it (we) last saw the deceased alive on May 4, 1967 , and that death occurred at 12:15M , from causes and on the date stated above.							
22a. SIGNATURE Edwin J. Jensen				22b. DATE SIGNED May 4, 1967		22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M. D.	
22d. ADDRESS Prince Georges General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City or Town) (County) (State) PARKERSBURG, WEST VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND				25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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CENTRAL OF DEATH

REPORT OF DEATH

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Report of Death
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. Page 5 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07135

CERTIFICATE OF DEATH

07115

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN lb <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>219-D RFD #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>John</u> ^{First} <u>F.</u> ^{Middle} <u>Marsh</u> ^{Last}		4. DATE OF DEATH <u>May</u> ^{Month} <u>22</u> ^{Day} <u>1967</u> ^{Year}		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/29/22</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (mechanical self-employed)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Vernon H Marsh</u>				14. MOTHER'S MAIDEN NAME <u>Bettie Davis</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Ruth Marsh</u> Address <u>Ahane</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal Hemorrhage secondary to ruptured esophageal varices.</u> DUE TO <u>5810</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Hepatic insufficiency, secondary to billiary cirrhosis</u> (c) <u> </u>																INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) <u> </u>															
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State)							
21. I certify that (I) (initials) attended the deceased from <u>5/19</u> to <u>5/22</u> 19<u>67</u> that (I) last saw the deceased alive on <u>5/22</u> 19<u>67</u>, and that death occurred at <u>11:30</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Norman J. Comer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>5/22/67</u>				22d. ADDRESS <u>3503 Pennyst Mt Rd</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/25/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>1st Lincoln</u>				23d. LOCATION (City, town or county) (State) <u>Calmar Manor Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. ...</u>				ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u> </u>				25b. REGISTRAR'S SIGNATURE <u>Charles ...</u>							
DATE <u>MAY 29 1967</u>				25c. REGISTRAR'S SIGNATURE <u> </u>															

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07136

07116

1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltville</u>				c. LENGTH OF STAY IN 1b <u>16 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4932 Powder Mill Rd.</u>				d. STREET ADDRESS <u>4932 Powder Mill Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Dallas James Marvel</u>				4. DATE OF DEATH <u>May 29 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 11, 1890</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Decorator Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James F. Marvel</u>				14. MOTHER'S MAIDEN NAME <u>Clara Belle Beach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 1918-1919</u>				16. SOCIAL SECURITY NO. <u>216-05-8564</u>		17. INFORMANT Address (Wife) <u>Mrs Grace Marvel Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>9 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> 19 <u>67</u> to <u>5/29</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> 19 <u>67</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert S. McCeney</u>				22b. DATE SIGNED <u>5/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert S. McCeney, M.D.</u>				22d. ADDRESS <u>ROBERT S. MCCENEY, M. D. 402 MAIN ST. LAUREL, MARYLAND 20810</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel, Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JUN 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G388 5/8/67 DC

07137

CERTIFICATE OF DEATH

07117

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>Three Mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> <u>47.3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATFOLL MANOR 4922 LASALLE</u>				d. STREET ADDRESS <u>2447 40th St N.W. Apt 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CECILIA</u> Last <u>MASON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/1911</u>	9. AGE (In years last birthday) <u>83</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick O' Connor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Burke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Dr Thomas Collins 322 H St N.E.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BOWEL</u> DUE TO <u>with generalized metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1967</u> to <u>May 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 1 1967</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F Collins</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>				22d. ADDRESS <u>322-H H NE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR <u>W.R. Hertenstein & Son Funeral Home 5152 Ga Ave N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07138

CERTIFICATE OF DEATH

07118

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUITLAND Nursing Home</u>		d. STREET ADDRESS <u>5410 Border Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOSEPH A MASSINO</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1887</u> 79 yrs.
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Frame Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Angelo Massino</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Columbia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frank A. Tubia-nephew Same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>6 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1967</u> to <u>May 2, 1967</u> that (I) (we) lost saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frank S. Pellegrini</u> M.D.		22b. DATE SIGNED <u>5.2. 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK S. PELLEGRINI</u>		22d. ADDRESS <u>3611 BRANCH AVE SE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-6-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St. N.E. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 5 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07139

CERTIFICATE OF DEATH

07119

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 1808 Benning Rd., N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last George B. Matthews		4. DATE OF DEATH Month Day Year 5 18 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-1-22
9. AGE (In years lost birthday) yrs. 45		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard Matthews		14. MOTHER'S MAIDEN NAME Margaret Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister and Medical Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 11 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEPATIC FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-6-67 , 19 67 , to 5-18-67 , 19 67 , that (I) (we) last saw the deceased alive on 5-17 , 19 67 , and that death occurred at 8:35 AM , from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 5-18-67	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.		22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORY CARVER MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) LAUREL, PRINCE G. MD
24. FUNERAL DIRECTOR George R. Auwiler		25a. REC'D BY REGISTRAR Rockwell	
25b. REGISTRAR'S SIGNATURE Charles Judge		MAY 24 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07140

CERTIFICATE OF DEATH

07120

1. PLACE OF DEATH a. COUNTY PG. Riverdale, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, DC. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,				c. LENGTH OF STAY IN lb 1 Day.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Hospital.				d. STREET ADDRESS 204 "E" Street N.W., Dodge Hotel			
3. NAME OF DECEASED (Type or print) First Edward Middle H Last McCrahon.				4. DATE OF DEATH Month May Day 2 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. DATE OF BIRTH 3-11-91	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? Amer.		17. INFORMANT Address Eugene Leland Hospital, 4408 Queensbury Rd,	
10a. USUAL OCCUPATION (Give kind of work done last night or morning, if even, if retired) Retired from DC. Government.				11. BIRTHPLACE (County & State, or foreign country) New York,			
13. FATHER'S NAME Alexander McCrahon				14. MOTHER'S MAIDEN NAME Mary Hughes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 579 03 1862			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO VENTRICULAR TACHYCARDIA & FIBR. (b) MYOCARDIAL INFARCTION, ACUTE (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH ONE DAY ONE WEEK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 2 MAY, 19 67, to 2 MAY, 19 67, that (I) (we) last saw the deceased alive on 2 MAY 19 67, and that death occurred at 6:15 PM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann OK M.D.				22b. DATE SIGNED 2 MAY 67			
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN DR. KOTHE				22d. ADDRESS RIVERDALE MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY Alexandria National	
23d. LOCATION (City or Town) Alexandria Va.				23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				DATE MAY 5 1967			

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3 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07141

07121

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 7-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 9 mo			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 637 D St., S.E.			
3. NAME OF DECEASED (Type or print) First Gerald Middle J. Last McDonough				4. DATE OF DEATH Month May Day 25 Year 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/28/1905	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 30 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR furniture co. UNKNOWN		11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas McDonough				14. MOTHER'S MAIDEN NAME Bertha Elbrecht			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-12-6787		17. INFORMANT decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver with duodenal ulcer and esophageal varices DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism with chronic brain syndrome and peripheral neuropathy; osteomyelitis rt. foot; replacement of lower aorta, abdominal aorta & iliac*						INTERVAL BETWEEN ONSET AND DEATH 30 min. 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/1/, 19 66 , to 5/25/, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/25/ 1967 , and that death occurred 08:20P M. from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 5/25/67		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	
22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.				22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 29, 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR Chambers & Co.				25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION
* arteries by nylon graft 1961; coronary arteriosclerosis.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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7-11-52

Prince Georges

Glenn Dale (trans)

Glenn Dale Hospital

Gerard

N

Swiss

Thomas McDonough

no

5-11-52

Thomas McDonough

Swiss

Gerard

Washington, D. C.

7-11-52

RECEIVED 7-11-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07142 CERTIFICATE OF DEATH 07122

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COLLEGE PARK		c. LENGTH OF STAY IN 1b 60 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9014 RHODE ISLAND AVE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COLLEGE PARK 16.1	
3. NAME OF DECEASED (Type or print) First MARY Middle ESTHER Last MCINTYRE		d. STREET ADDRESS 9014 RHODE ISLAND AVE	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 24 1899	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR.		10b. KIND OF BUSINESS OR INDUSTRY INF. AGENCY U.S. GOVT	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HENRY MCINTYRE		14. MOTHER'S MAIDEN NAME LORA ANNIE REYNOLDS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 220-44-8890	
17. INFORMANT RUTH C. MCINTYRE		Address SAME AS #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis (c) Cerebral apoplexy		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 4 yrs. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960, to May 17, 1962, that (I) (we) last saw the deceased alive on May 17, 1962, and that death occurred at 109 M, from the causes and on the date stated above.			
22a. SIGNATURE N.B. STEWARD		22b. DATE SIGNED May 18, 1962	
22c. PHYSICIAN'S NAME (Type) N.B. STEWARD MD.		22d. ADDRESS LAUREL - MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 20 1962	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d. LOCATION (City, town or county) (State) BLADENSBURG MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO RIVERDALE, MARYLAND		25a. REC'D BY REGISTRAR DATE MAY 22 1962	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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001130

RECEIVED 10 APR 1965

001130

TO: DIRECTOR, ARMY RESEARCH OFFICE (ARO)
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several paragraphs of text, some of which may be headings or subheadings, but the specific content cannot be discerned.]

[Faint vertical text on the right margin, possibly a reference or classification code.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07143

CERTIFICATE OF DEATH

07123

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE NEW YORK b. COUNTY ONEIDA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB BASE		c. LENGTH OF STAY IN 1b 1 Mo. 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UTICA 69-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			d. STREET ADDRESS 829 MILDRED AVENUE		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J MCSALLY			4. DATE OF DEATH Month Day Year MAY 28 1967		
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 29 JUN 33		9. AGE (In years lost birthday) 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (County & State, or foreign country) ONEIDA, NEW YORK	
13. FATHER'S NAME JOSEPH J. MCSALLY			14. MOTHER'S MAIDEN NAME GERTRUDE MACCRACKEN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 1953-1967 095-20-9692		17. INFORMANT MOTHER Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1909 IMMEDIATE CAUSE (a) CARDIAC-RESPIRATORY EMBRASSMENT DUE TO (b) METASTATIC DISEASE DUE TO (c) MALIGNANT MELANOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 27 Apr , 19 67 , to 28 May , 19 67 , that (X) (we) last saw the deceased alive on 28 May , 19 67 , and that death occurred at 10:30 PM from causes and on the date stated above.					
22a. SIGNATURE <i>[Signature]</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 28 May 1967	
22c. PHYSICIAN'S NAME (Type) DIXON YESTE, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash Dc 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-31-1967		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery Whitesboro New York	
24. FUNERAL DIRECTOR W.W. Chambers Co		ADDRESS 517-11-SPSE Wash D.C.		25a. REC'D BY REGISTRAR JUN 1 1967	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

11170

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11170

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07144

07124

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO'S.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park, Md.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 6904 Carleton Terrace			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS College Park, Maryland			
3. NAME OF DECEASED (Type or print) STANLEY REYNOLDS McVEY				4. DATE OF DEATH Month MAY Day 9 Year 1967			
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-77	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (County & State, or foreign country) Cecil County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMEN McVEY				14. MOTHER'S MAIDEN NAME MARGARET REYNOLDS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 67-076-963		17. INFORMANT W.C. McVEY - 6904 Carleton Terrace			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage 331X DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 20 YRS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 17, 1967 to MAY 9, 1967 , that (I) (we) last saw the deceased alive on MAY 17, 1967 , and that death occurred at 6 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Herbert G. Brandes M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MAY 9, 1967	
22c. PHYSICIAN'S NAME (Type) HERBERT BRANDES				22d. ADDRESS 3400 Univ. Blvd. E. Adelphi, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/11/67		23c. NAME OF CEMETERY OR CREMATORY ROSEBANK CEM.		23d. LOCATION (City, town or county) (State) CALVERT, CECIL CO, MD	
24. FUNERAL DIRECTOR'S SIGNATURE RALPH M. REED				ADDRESS RISING SUN, MD		25a. REC'D BY REGISTRAR MAY 12 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALSO

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07125

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 124 Mohican Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Miller				4. DATE OF DEATH Month 5 Day 7 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 June 1884		9. AGE (In years last birthday) 82 yrs.	10. UNDER 1 YEAR Months 5 Days 7 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Forest Hills, Md. Francis Miller-124 Mohican Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. -		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 5-8-67		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 6-8-1967		23c. NAME OF CEMETERY OR CREMATORY St. Bonaventure Cem.		23d. LOCATION (City or Town) (County) (State) Allegany, N.Y.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR DAV 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

UNITED STATES
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OFFICE OF THE

NAVY DEPARTMENT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07146

07126

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 3739 Marlborough Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle C Last Miller				4. DATE OF DEATH Month 5 Day 1 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-1905		9. AGE (In years lost birthday) yrs. 61	10. IF UNDER 1 YEAR Months 5 Days 1 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done) Mining Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Miller				14. MOTHER'S MAIDEN NAME Stella E. Mates			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 166 10 3516		17. INFORMANT Address Elizabeth Miller Same as #2 (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH minutes over 6 yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-1-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Oakwood		23d. LOCATION (City or Town) (County) (State) Bedford Va.	
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAY 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

628

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$$\left(\frac{1}{\sqrt{2}} \right)$$

4. *Chlorophyll a* and *Chlorophyll b* contents were determined by spectrophotometry using the method of Lichtenthaler and Whistler (1973).

Deputy Medical Examiner for Prince Georges County, released remains to this hospital for disposition and preparation of Death Certificate. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rephase carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07147

CERTIFICATE OF DEATH

08615

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB BASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 5541 68th Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last ELWOOD WITTNER MILSON		4. DATE OF DEATH Month Day Year MAY 31 1967	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 May 1930
9. AGE (In years lost birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		10b. KIND OF BUSINESS OR INDUSTRY USN	
11. BIRTHPLACE (County & State, or foreign country) GIARD, IOWA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL MILSON		14. MOTHER'S MAIDEN NAME LUCILLE WITTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES Jun47-May67		16. SOCIAL SECURITY NO. 484-24-8575	
17. INFORMANT Wife		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO (b) CARDIAC ARREST DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 31 May, 1967 , to 31 May, 1967 that (X) (we) last saw the deceased alive on 31 May 1967 , and that death occurred at 5:45 AM , from causes and on the date stated above.			
22a. SIGNATURE David L. Piegras, M.D. M.D.		22b. DATE SIGNED 31 May 1967	
22c. PHYSICIAN'S NAME (Type) DAVID G. PIEGRAS, CAPT, USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/5/67	
23c. NAME OF CEMETERY OR CREMATORY W.W. CHAMBERS CO. INC WASH. D.C.		23d. LOCATION (City or Town) (County) (State) MIDWAY CITY, CALIF.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC WASH. D.C.		25a. REC'D BY REGISTRAR DATE JUN 7 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

IN SENATE

JANUARY 1, 1910

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1909

ALBANY:

J.B. LIPPINCOTT & CO., PRINTERS

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #12 Film #G389 6/12/67 pc

07148

CERTIFICATE OF DEATH

07127

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		10.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Paint Branch Nursing Home</i>				d. STREET ADDRESS <i>4000 Oliver St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>FRANK</i> Middle <i>MONTEBELLO</i> Last <i>MONTEBELLO</i>				4. DATE OF DEATH Month <i>May</i> Day <i>31</i> Year <i>1967</i>			
5. SEX <i>m.</i>	6. COLOR OR RACE <i>w.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-28-1880</i>	9. AGE (In years last birthday) <i>87</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>	
13. FATHER'S NAME <i>Francis Montebello</i>				14. MOTHER'S MAIDEN NAME <i>Helen Bryan</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>579148018</i>		17. INFORMANT <i>Rose LaVincenza</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>10 yrs.</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <i>D</i> (this hospital) attended the deceased from <i>12-7</i> , 19 <i>66</i> to <i>5-31</i> , 19 <i>67</i> , that <i>(D)</i> (we) last saw the deceased alive on <i>5-31</i> , 19 <i>67</i> , and that death occurred at <i>10:30</i> P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>R.D. Bauer M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>R.D. Bauer M.D.</i>				22d. ADDRESS <i>2515 Buckleys Rd. Adelphi Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 5, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i>		23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON, D.C.</i>	
24. FUNERAL DIRECTOR <i>GASCH'S</i>				ADDRESS <i>4739 Baltimore Ave. Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 5 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>R. D. Bauer</i>			

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

2250

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07143

07128

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills	
c. LENGTH OF STAY IN lb DOA		d. STREET ADDRESS 4105 Southern Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Thomas Moore		4. DATE OF DEATH Month Day Year 5 5 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-25
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert M. Moore, Sr		14. MOTHER'S MAIDEN NAME Beulah M. Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II & Korea		16. SOCIAL SECURITY NO. 579 22 5731	
17. INFORMANT Beverly H. Moore		Address Temple Hills, Md 5212-Canterbury Way SE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull fracture DUE TO (c) driver of car which ran off road and hit tree			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver of car which ran off road and hit tree	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 2:25am 5-5 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4300 Suitland Rd.	20f. (City or town) (County) (State) Suitland P.G. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 5-6-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 8-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07150

CERTIFICATE OF DEATH

07129

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4901 Taylor Street	
3. NAME OF DECEASED (Type or print) Julia First L. Middle Morrison Last		4. DATE OF DEATH Month May Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1881
9. AGE (In years and birth day) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Henry R. Kirk		14. MOTHER'S MAIDEN NAME Julia Cox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Loretta C. Flood Same as #2 (daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Permanic Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-1 , 19 50 , to 5-31 , 19 67 that (I) (we) last saw the deceased alive on 5-27 19 67 and that death occurred at 7:15 AM , from causes on and on the date stated above.			
22a. SIGNATURE A. Deitz		22b. DATE SIGNED 5-31-67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS Prince George Plaza Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/67	
23c. NAME OF CEMETERY OR CREMATORY Glenwood		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR JUN 5 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07151

CERTIFICATE OF DEATH

07130

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>			c. LENGTH OF STAY in 1b <u>12 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> <u>16-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>713 Rittenhouse Street</u>				d. STREET ADDRESS <u>713 Rittenhouse Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>S.</u> Last <u>Mullen</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>19 67</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 17, 1908</u>		
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dept Manager</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Woodward & Lothrop</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Scotson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Naughton</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>577-01-5344</u>		17. INFORMANT <u>Charles Mullen</u> Address <u>713 Rittenhouse Street W. Hyattsville, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> , 19 <u>65</u> to <u>5/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> , 19 <u>67</u> , and that death occurred at <u>4:40</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>John F. Finnegan</u>				22b. DATE SIGNED <u>5/31/67</u>		22c. PHYSICIAN'S NAME (Type) <u>John F. Finnegan</u>		
22d. ADDRESS <u>1746 K. St., N. W., Washington, D. C.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>		
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> <u>8434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUN 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

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62-10370-2

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

07152

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07131

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Forest Heights Md 1611</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Prince Geo General</i>		d. STREET ADDRESS <i>332 Huron Dr</i>	
3. NAME OF DECEASED (Type or print) <i>JAMES RAY MUNDALL</i>		4. DATE OF DEATH <i>May 21 19 67</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 24-1922</i>
9. AGE (In years last birthday) <i>45</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate - Mundell Realty Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>West Virginia</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George H. Mundell</i>		14. MOTHER'S MAIDEN NAME <i>Isis M. Ringkey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <i>STELLA V. Mundell - SAME AS ITEM #2</i>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i> <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <i>Hypertensive CV Disease</i> OUE TO (c) <i>yes</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dayton Watkins</i>		22. DATE SIGNED <i>5-21-67</i>	
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>		Address (Street, city, town, or county) <i>5-21-67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<i>Burial</i>	<i>May 23-1967</i>	<i>Brick Church Cemetery</i>	<i>Huttonsville, West Virginia</i>
24. FUNERAL DIRECTOR <i>Simmons Bros</i>		25a. REC'D BY REGISTRAR	
<i>Simmons Bros. 1661-Good Hope Rd SE Wash DC</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>MAY 22 1967</i>			

27125

Page 21

THE 14-12-12

WEST VIRGINIA

REAL ESTATE INVESTMENT CO.

IS. M. RINDKY

GEORGE H. MUNDOLL

STELLA V. MUNDOLL - Same as Item #2

Handwritten signature or stamp at the bottom right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07153

CERTIFICATE OF DEATH

07132

1. PLACE OF DEATH a. COUNTY <u>PR. GEORGES.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>DC.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>	
c. LENGTH OF STAY IN 1b <u>19 DAYS</u>		d. STREET ADDRESS <u>1824 17th St. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Blue View Gardens</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGATHA B.</u> Middle <u>MUSE</u> Last <u>MUSE</u>		4. DATE OF DEATH Month <u>5-</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1891</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student Apt. Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APT BLDG.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Benedikt</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Schuetter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>577-03-4150-A</u>		17. INFORMANT <u>Miss ELEANOR CHARLES - 1824-17th St. N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VASCULAR COLLAPSE</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMATOSIS</u> DUE TO (c) <u>BRONCHOGENIC CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>67</u> , and that death occurred at <u>1:50 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin, M.D.</u>		22b. DATE SIGNED <u>5/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/22/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Memo. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Rd 633 Rd Extra Hyattsville, MD</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>		25a. REC'D BY REGISTRAR <u>Washington, D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 29 1967</u>	

07123

CERTIFICATE OF ANALYSIS

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[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "PLACE" and "ANALYSIS" are faintly visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07154

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07133

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY in DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Charles Negron			4. DATE OF DEATH 5 31 1967		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 18 Nov. 1938		
9. AGE (In years lost birthday) 28 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
11. BIRTHPLACE (State or foreign country) New York City, N.Y.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Eustaquio Negron			14. MOTHER'S MAIDEN NAME Helena Correa		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 7-5-60 6-4-66			16. SOCIAL SECURITY NO. 066-34-4920		
17. INFORMANT Mrs. Frieda Negron (above address) (wife)			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occlusion of anterior descending coronary artery 4201 DUE TO Arteriosclerotic heart disease, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH minutes unknown		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.			22. DATE SIGNED 6-1-67		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 6/3/67		
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.			23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			25a. REC'D BY REGISTRAR JUN 5 1967		
ADDRESS Mt. Rainier, Maryland			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G389 6/6/67 pc

CERTIFICATE OF DEATH

07155

07134

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY in 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Gen. Hosp.</u>				d. STREET ADDRESS <u>7033 ALBENTOWN RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Newman</u> Last <u>Newman</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/89</u>	9. AGE (In years, lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pr. Geo's. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eugene Newman</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Proctor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary E. Neal</u> Address <u>7033 N. K. town rd. Clinton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE FAILURE</u> <u>5372</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CHRONIC PULMONARY DISEASE</u> DUE TO <u>WITH EMPHYSEMA AND</u> (c) <u>CONGESTIVE HEART FAILURE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> Min. <u> </u> <u>None</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1957</u> to <u>PRESENT</u> that (I) (we) last saw the deceased alive on <u>MAY 27 1967</u> , and that death occurred at <u>9:40 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>				22d. ADDRESS <u>8808 OLD BRANCH AVE. CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Ch. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Clinton P. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>Marcell Adams Aquasco, Md.</u>				25a. REC'D. BY REGISTRAR DATE <u>JUN 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07156

CERTIFICATE OF DEATH

07135

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Hampshire b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keene
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Nursing Home		d. STREET ADDRESS 53 Trobate Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Peter Last Nolin		4. DATE OF DEATH Month May Day 1 , Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1888
9. AGE (In years birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Men's clothing		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (County & State, or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Pierre Nolin		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, Yes , or unknown) (If yes give year or dates of service) WW I		16. SOCIAL SECURITY NO. 002 01 0284	
17. INFORMANT Barbara McLeod		5213 Varnum St. Bladensburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Concussion of Frontal		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec , 1966, to Feb , 1967, that (I) (we) last saw the deceased alive on 5-1 1967, and that death occurred at 3P M, from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren		22b. DATE SIGNED 5-1-67	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-5-67	
23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH		23d. LOCATION (City or Town) (County) (State) KEENE, NEW HAMPSHIRE	
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS		25a. REC'D BY REGISTRAR MAY 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1998

06150

5154

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07157

CERTIFICATE OF DEATH

07136

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>				c. LENGTH OF STAY IN <u>6 1/2 hrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>				16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland General Hospital</u>				d. STREET ADDRESS <u>4020 Brooks Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARIANNE</u> Middle <u>C</u> Last <u>NONEMAN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-02</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zanger, Ferdinand</u>				14. MOTHER'S MAIDEN NAME <u>Kraus, Sophia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>385-010703</u>		17. INFORMANT <u>Mr. Ward, Barnett, Clinton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction and</u> Massive G.I. Hemorrhage (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-6</u> <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - possible Ulcers</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-8</u> , 19 <u>67</u> , to <u>5-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-8</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>MAY 9th, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R LAPIN, MD</u>				22d. ADDRESS <u>CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BATTLE CREEK MEMORIAL PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>BATTLE CREEK, MICH.</u>	
24. FUNERAL DIRECTOR <u>M. W. HYSONG CO INC.</u> ADDRESS <u>1300 - N ST. NW</u>				25a. REC'D BY REGISTRAR <u>Per Thomas M. Hysong</u> <u>WASH. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MAY 10 1967

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1914

TESTIMONY OF

07151

[Faint, mostly illegible handwritten text, possibly a transcript or report. Some words like "I am", "the", "and" are visible.]

2

WITNESSES:
SUBSCRIBED AND SWORN to before me this 1st day of May, 1914.
Notary Public for the District of Columbia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07158

CERTIFICATE OF DEATH

07137

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WALDORF MD.</u> b. COUNTY <u>PRINCE CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>2-21-67</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>		d. STREET ADDRESS <u>RT. 1 BOX 404</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINEVIEW GARDENS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>T.</u> Last <u>NORVILL</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-1895</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CULPEPPER, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD H. HANSBOROUGH</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET BONTZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218 347 022-B</u>	
17. INFORMANT <u>HUSBAND</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 7, 1967</u> to <u>May 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 17, 1967</u> , and that death occurred at <u>3:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thom G. Hadley</u>		22b. DATE SIGNED <u>May 7 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. G. HADLEY</u>		22d. ADDRESS <u>4601 Nichols Ave NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-10-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Waldorf, Charles MD</u>	
24. FUNERAL DIRECTOR <u>Hunt Funeral Home Waldorf Md</u>		25. REC'D BY REGISTRAR <u>MAY 11 1967</u>	
26. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		27. REGISTRAR'S SIGNATURE	

07170

CONTINUATION OF DEATH

07170

MA 11 2011

10/10/10

RECEIVED 10/10/10

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07160

CERTIFICATE OF DEATH

07139

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr 30 m	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d. STREET ADDRESS 3615 Eastern Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Minnie A O'Brien		4. DATE OF DEATH Month Day Year May 23 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Oct., 1915
9. AGE (In years lost birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Cameron		14. MOTHER'S MAIDEN NAME Susan Greer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Thos. J. O'Brien (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 hrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1950 , to 5/23 , 19 67 , that (I) (we) last saw the deceased alive on 5/23 19 67 , and that death occurred at 2:40 M, from causes and on the date stated above.			
22a. SIGNATURE Norman D. Comen		22b. DATE SIGNED 5/23/67	
22c. PHYSICIAN'S NAME (Type) Norman D. Comen		22d. ADDRESS 3503 Penny St Mt Rainier Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAY 29 1967	
ADDRESS Mt. Rainier, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATEMENT OF DEATH

Prince George

Prince George

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Prince George General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07161

CERTIFICATE OF DEATH

07140

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		d. STREET ADDRESS <u>6712 Darby Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>M.</u> Last <u>Owens</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/99</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosiery worker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Golden Belt Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wilson Co., N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Major Barnett</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Bunn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>242-01-7086</u>		17. INFORMANT <u>Mrs. Minnie Weil, 6712 Darby Rd., Hyattsville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the pancreas</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 9, 1967</u> , to <u>May 13, 1967</u> , that (I) (we) lost saw the deceased alive on <u>May 13, 1967</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Hernandez</u>		22b. DATE SIGNED <u>5/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. J. HERNANDEZ, MD</u>		22d. ADDRESS <u>PRINCE Geo. Gen Hospital.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-16-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Durham N.C.</u>	
24. FUNERAL DIRECTOR <u>MURPHY FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 18 1967</u>	

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0716

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07162

CERTIFICATE OF DEATH

07141

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) e. STATE Md. b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie, Md.		c. LENGTH OF STAY IN lb 6 weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock, Md. RFD.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) residence				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Verna M. Middle Parks Last 				4. DATE OF DEATH Month May Day 5 Year 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1903			
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none		9. AGE (In years last birthday) 64 yrs.			
11. BIRTHPLACE (County & State, or foreign country) Blande, Va.				12. CITIZEN OF WHAT COUNTRY? USA.					
13. FATHER'S NAME Robert S. Venable				14. MOTHER'S MAIDEN NAME Lula M. Imabert					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no				16. SOCIAL SECURITY NO. none					
17. INFORMANT Lewis M. Parks				Address Bowie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) carcinoma of liver DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 2 days 4 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) I diabetes mellitus 2 hypertension								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/15/67 , 19 67 , to 5/5/67 , 19 67 , that (I) (we) last saw the deceased alive on 5/4/67 , 19 67 , and that death occurred at 3:28 PM , from the causes and on the date stated above.									
22a. SIGNATURE Henry A. Wise M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Typed) Henry A. Wise				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY Concord Cem.		23d. LOCATION (City, town or county) (State) Federalburg, Md. RFD.			
24. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams				25. REC'D BY REGISTRAR MAY 11 1967					
25b. REGISTRAR'S SIGNATURE Charles Judge									

07163

Prince George

Boyle, Ma.

residence

male

housewife

Robert A. Venable

none

provision

cardioma of liver

1 rhinops mollus

2 rhinops

3-11

Concord, N.H.

April 1, 1907

1 2
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07142

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights 16-1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 1528 62nd. Place	
3. NAME OF DECEASED (Type or print) First Middle Last DUSAN E. PARMA		4. DATE OF DEATH Month Day Year 5 11 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Jan. 1890
9. AGE (In years lost birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min. 24 24 00 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME EDWARD PARMA		14. MOTHER'S MAIDEN NAME BETTY NEUMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 360 26 0972	
17. INFORMANT JIRI PARMA		Address 1528 62nd PLACE S E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 5-12-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF MAY 13 1967	
23c. NAME OF CEMETERY OR CREMATORY LEES CREMATORY		23d. LOCATION (City or Town) (County) (State) WASHINGTON D C	
24. FUNERAL DIRECTOR LEE FUNERAL HOME		25a. REC'D BY REGISTRAR MAY 17 1967	
ADDRESS 300 4th ST N E		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07164

07143

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>D. W. Patterson</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville - md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS 16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Rehabilitation Center</u>		d. STREET ADDRESS <u>7704 DUBLIN DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>Dewitt C. Patterson</u>		4. DATE OF DEATH <u>MAY 16 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nimrod Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Lucindy Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>EARL G PATTERSON SAME AS #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>atherosclerotic heart disease</u> DUE TO (c) <u>5 periods of mild asthma</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>67</u> , to <u>16 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>15 May</u> 19 <u>67</u> , and that death occurred at <u>12:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Hargis</u>		22b. DATE SIGNED <u>16 May 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Hargis</u>		22d. ADDRESS <u>6412 Canolton Ct</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES MD</u>
24. FUNERAL DIRECTOR <u>Robert E. Wickham</u>		25a. MAY 18 1967 25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

RECEIVED IN THE OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

3512

RECEIVED IN THE OFFICE OF THE SECRETARY OF THE ARMY

3512

Lucy Reed

Harold Patterson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07165

CERTIFICATE OF DEATH

07144

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General HOsPital		d. STREET ADDRESS 6931 Allison St.	
3. NAME OF DECEASED (Type or print) First Milton Middle T. Last Patterson		4. DATE OF DEATH Month May Day 4 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/01
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAM FITTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) TENN.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES PATTERSON		14. MOTHER'S MAIDEN NAME BLANCHE THORNBURG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-09-9711	
17. INFORMANT FLORENCE H. PATTERSON		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma DUE TO 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Obstruction DUE TO (c) Metastatic Lung		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. , 19 66 , to May 4 , 19 67 , that (I) (we) last saw the deceased alive on May 4 , 19 67 , and that death occurred at 8:25 AM , from causes and on the date stated above.			
22a. SIGNATURE Ohannes Sahakyan		22b. DATE SIGNED May 5, 1967	
22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M.D.		22d. ADDRESS 5813 Landover Road, Cheverly, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-8-1967	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS 60 RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE MAY 11 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

07163

CHURCH OF ENGLAND

1914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07166

CERTIFICATE OF DEATH

07145

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital				d. STREET ADDRESS 5802 Greenleaf Rd			
3. NAME OF DECEASED (Type or print) HENRIETTA First Middle Last				4. DATE OF DEATH MAY 29 1967 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 1/26/1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) Penn.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George Christ				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT William Pearce Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) Arteriosclerotic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIOVASCULAR DUE TO Disease (c) INTERVAL BETWEEN ONSET AND DEATH 6 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from March 1961 to May 29, 1967 that (II) (we) last saw the deceased alive on May 29, 1967 , and that death occurred at 9:25 PM from causes and on the date stated above.			
22a. SIGNATURE William D. Rossen				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/30/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 5701 85th AVE, HYATTSVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/67		23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City or Town) (County) (State) Ft Myer, Va.	
24. FUNERAL DIRECTOR Lee Funeral Home				ADDRESS Washington DC		25a. REC'D BY REGISTRAR JUN 5 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

07160

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

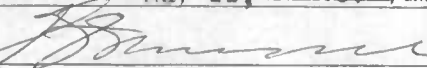
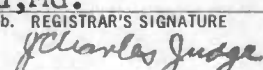
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07167

Item #8 Film #G388 5710/07

07146

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 7612 Fountainbleau Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Annie J. Penn		4. DATE OF DEATH May 11 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/96		9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Johnson				14. MOTHER'S MAIDEN NAME Daisy M. Wilkinson Wilkerson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-20-6797		17. INFORMANT Mrs Clare J. Weger-daughter					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 days														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from April 24, 1967 , to May 11, 1967 , that (I) (we) last saw the deceased alive on May 11, 1967 , and that death occurred at 10A.M. from the causes and on the date stated above.																			
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Frederick E. Musser, M.D.												22b. DATE SIGNED May 12, 1967							
22d. ADDRESS 4410-74th Ave. Hyattsville, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-13-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) (State) Suitland, Md.									
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St N.E. Wash, D.C. 20002												25a. REC'D BY REGISTRAR MAY 15 1967				25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton d. STREET ADDRESS 7612 Fountainbleau Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Clarence M. Penn			First Clarence		Middle M.		Last Penn		4. DATE OF DEATH Month May Day 8 Year 19 67		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/3/94		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 10 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				10b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jesse Penn					14. MOTHER'S MAIDEN NAME Mary Ellen Hardy						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 579 05 9249		17. INFORMANT Hospital records						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) thrombosis of rt. vertebral artery? thromboembolism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary thrombo-emboli - bilateral INTERVAL BETWEEN ONSET AND DEATH 2 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Suitland, Md.		(County) Prince Georges (State) Md.		
21. I certify that (I) (this hospital) attended the deceased from 5/10/67 , to 5/18/67 , that (I) (we) last saw the deceased alive on 5/18/67 , and that death occurred at 3:00 PM , from the causes and on the date stated above.											
22a. SIGNATURE F. E. Musser					22b. DATE SIGNED 5/18/67			22c. PHYSICIAN'S NAME (Type) F. E. Musser			
22d. ADDRESS 4410 78th Ave Hyattsville			22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/11/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION (City, town or county) Suitland, Md.			
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash. D.C.					25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge				
25c. DATE MAY 11 1967											

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF BIOLOGY
CHICAGO, ILLINOIS 60637

Dear Sir,
I am writing to you in response to your letter of the 11th of June, 1967, regarding the matter of the University of Chicago Press.

I am sorry that I cannot give you a more definitive answer at this time, but the matter is still under consideration. I will be sure to let you know as soon as a final decision has been reached.

I am sure that you will understand the need for careful consideration of this matter, and I appreciate your patience in waiting for a response.

Sincerely,
[Signature]
[Name]
[Title]
[Address]

Very truly yours,
[Signature]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07163

CERTIFICATE OF DEATH

07148

1. PLACE OF DEATH a. COUNTY <u>Prince George Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN lb <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stewart Lane 161 M.D. (Clinton)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lincoln Gardens Health Center</u>				d. STREET ADDRESS <u>5640 Alice Drive - M.D.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>PLACOS</u> Last <u>PLACOS</u>				4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1898</u>	9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min.		11. IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Pappas</u>				14. MOTHER'S MAIDEN NAME <u>Helser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>110</u>		17. INFORMANT <u>John Placos (son) - 5640 Alice Dr</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>451X</u> IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO (b) <u>Abdominal aorta aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>30 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-8</u> , 19 <u>67</u> , to <u>5-10</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>5-10</u> , 19 <u>67</u> , and that death occurred at <u>4:40</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Arlington, Virginia</u>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>Simmons Bros & Son</u>		ADDRESS <u>1661 Good Roads Rd</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00150

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07170

CERTIFICATE OF DEATH

07149

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>Prince Georges</u> Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		d. STREET ADDRESS <u>6512 C. St.</u>	
3. NAME OF DECEASED (Type or print) <u>Henry F. POHL</u>		4. DATE OF DEATH <u>5</u> Month <u>May</u> <u>16</u> Day <u>1967</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>	9. AGE (In years last birthday) <u>90</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-24-2569</u>	
17. INFORMANT <u>Austin F. Pohl</u>		Address <u>4903 71st AVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO <u>cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO <u>coronary artery disease</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Stroke 3 days prior to admission</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-29-1965</u> , 19 <u>65</u> , to <u>May 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>5/15/1967</u> , and that death occurred at <u>4:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky</u>		22b. DATE SIGNED <u>5/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>		22d. ADDRESS <u>3408 R.I. Ave Mt Rainier, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5.20.67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25. REC'D BY REGISTRAR <u>MAY 19 1967</u>	
ADDRESS <u>300.4th st N E D C</u>		25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all other events within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07171

CERTIFICATE OF DEATH

07150

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			16-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3402 Bunker Hill Rd/			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clvde Middle P Last Pulley				4. DATE OF DEATH Month May Day 21 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Dec., 1924	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY SELF*EMPLOYED		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES R. PULLEY				14. MOTHER'S MAIDEN NAME STELLA EATMON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 241-30-8140		17. INFORMANT Mrs. Faye K. Pulley Address 715 Edmund St. Raleigh, N. C. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pancreatitis 5890 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from May 19, 1967, to May 21, 1967, that the (we) last saw the deceased alive on May 21, 1967, and that death occurred 10.00PM from causes and on the date stated above.							
22a. SIGNATURE T. J. Hernandez MD				22b. DATE SIGNED 5/22/67		22c. PHYSICIAN'S NAME (Type) T. J. Hernandez MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-67	23c. NAME OF CEMETERY OR CREMATORY OAKWOOD		23d. LOCATION (City or Town) (County) (State) RALEIGH, NORTH CAROLINA		
24. FUNERAL DIRECTOR GASCH'S		25a. REC'D BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE /Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 1/2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 9109 Utica Place	
3. NAME OF DECEASED (Type or print) First William Middle S. Last Pumphrey		4. DATE OF DEATH Month May Day 27 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-02
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coppersmith		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard	11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clifford Pumphrey	
14. MOTHER'S MAIDEN NAME Alice Spencer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 213-44-3706		17. INFORMANT Mrs. Edna M. Orr - thorpe St., Hy., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) chronic glomerular nephritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary artery disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-5 , 19 67 , to 5-27 , 19 67 , that (I) (we) last saw the deceased alive on 5-27 , 19 67 , and that death occurred at 7:10 M, from causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 5-27-67	
22c. PHYSICIAN'S NAME (Type) George Hageage		22d. ADDRESS 3717-38th Cottage City Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.		25a. REC'D BY REGISTRAR JUN 2 1967	
ADDRESS Mt. Rainier Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

00172

CENTRAL DE DEATH

MAINTAINING RECORDS IN ORDER
THAT THE DEATHS OF ALL PERSONS WHO DIE IN THE U.S.A.

Business Center

Arrival and

Time of Death

Landover

1/1/19

Gravely

Union Union Union

Prince George's General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

74

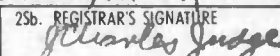
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07173

CERTIFICATE OF DEATH

07152

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7-1/2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Cape Anne	
3. NAME OF DECEASED (Type or print) FREDERICK Fredrick H. Purschwitz		4. DATE OF DEATH Month May Day 12 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/05
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICIAN		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURAL DEPT U.S.	
11. BIRTHPLACE (County & State, or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY PURSCHWITZ		14. MOTHER'S MAIDEN NAME ANNIE RAU	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215447877	
17. INFORMANT ROSALEE PURSCHWITZ		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 5400 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ACUTE HEMORRHAGIC PANCREATITIS DUE TO ACUTE PENETRATING GASTRIC ULCER WITH HEMORRHAIGE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) the hospital attended the deceased from May 3, 1967 , to May 12, 1967 , that (I) we last saw the deceased alive on May 12, 1967 , and that death occurred at 6:45 M. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED May 12, 1967	
22c. PHYSICIAN'S NAME (Type) Robert B. G. Sasseer, M.D.		22d. ADDRESS R. F. D 2150, Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 15, 1967	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND
24. FUNERAL DIRECTOR W. W. CHAMBERS, Co. RIVERDALE, MARYLAND		25a. REC'D BY REGISTRAR DATE MAY 18 1967	25b. REGISTRAR'S SIGNATURE 

07173

STATE OF TEXAS

07173

County of _____

State of Texas

Know all men by these presents, _____

of the County of _____ State of Texas

do hereby certify that _____

is the true and correct owner of _____

and that the same is subject to the lien of _____

in the sum of _____ Dollars

and that the same is to be paid to _____

on or before the _____ day of _____

19____ A.D. and _____ A.M.

and that the same is to be paid to _____

in the sum of _____ Dollars

and that the same is to be paid to _____

on or before the _____ day of _____

19____ A.D. and _____ A.M.

and that the same is to be paid to _____

in the sum of _____ Dollars

and that the same is to be paid to _____

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07174

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07153

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB eight hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1114 Huron Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jackie William Ray				4. DATE OF DEATH Month Day Year 5 26 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-32		9. AGE (In years lost birthday) yrs. 35	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grant Sherman Ray				14. MOTHER'S MAIDEN NAME Ruth C. Carson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Grant S. Ray Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 8124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Skull Fractures DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8:08am 5-26 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Balt.-Wash. Pkwy.		20f. (City or town) (County) (State) near Rte. 495, P.G., Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED 5-28-67	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR W.W. Chambers, Co. Inc. Washington, D.C.				25a. REC'D BY REGISTRAR JUN 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07175

CERTIFICATE OF DEATH

07154

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		c. LENGTH OF STAY IN 1b ...	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5103 MARLBORO PIKE		d. STREET ADDRESS 6713 MUNSEY ST.	
3. NAME OF DECEASED (Type or print) First John Middle Elmer Last Rayford		4. DATE OF DEATH Month May Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE Ca.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 22, 1874
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathew Rayford		14. MOTHER'S MAIDEN NAME Catherine Carr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-50-9334	
17. INFORMANT Mrs. Elmer E. Rayford		Address 373 Edgewater Rd. Pasadena, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CARDIAC ARTERIOSCLEROSIS DUE TO (c) Myocardial Infarction Secondary Arteriosclerosis 4-542			INTERVAL BETWEEN ONSET AND DEATH 10 min 30 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/18 , 19 66 , to May 23, 1967 , that (I) (we) last saw the deceased alive on May 23, 1967 , and that death occurred at 6 p.m. from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Cullen		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 23 May 67
22c. PHYSICIAN'S NAME (Type) Thomas F. Cullen		22d. ADDRESS 5103 Marlboro P.K.E.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-26-67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	23d. LOCATION (City or Town) (County) (State) SUITLAND MARYLAND
24. FUNERAL DIRECTOR GASCH'S		25a. REC'D BY REGISTRAR 4739 Baltimore Ave. Hyattsville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 26 1967	

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

4515

1994-1995

3

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07176

CERTIFICATE OF DEATH

07155

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> <u>16-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u>		d. STREET ADDRESS <u>4307 39th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>ADALON</u> Middle <u>B.</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>P</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-15</u>
9. AGE (In years lost birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Lynchburg, Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Clarkson</u>	
14. MOTHER'S MAIDEN NAME <u>Susie Roberts</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>577-05-8939</u>		17. INFORMANT <u>Mrs. Barbara Holtzelaw</u> Address <u>3500-Dean Dr. Hy., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> (Daughter) <u>clinical</u> DUE TO <u>6000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>subarachnoid hemorrhage</u> <u>recent</u> DUE TO (c) <u>Chronic Pyelonephritis</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1967</u> to <u>May 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 27, 1967</u> , and that death occurred at <u>9:55 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin L. Miller</u>		22b. DATE SIGNED <u>28 May 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>JUN 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00190

UNITED STATES DEPARTMENT OF AGRICULTURE

00190

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07156

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>RT 2 Jumpowdermill Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALMA Inez</u>	First Middle Last <u>RICE</u>	4. DATE OF DEATH <u>May 22</u>	Year <u>1967</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30 1922</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>44 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Price</u>		14. MOTHER'S MAIDEN NAME <u>Mary Leasure</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Pr Geo Police</u>		<u>Maryland State Police</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confusions & Lacerations of Brain - Gunshot inst.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wound</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Subject has had mental treatment Post Sural War.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Subject shot self in head</u>	
20c. TIME OF INJURY Month, Day, Year <u>May 22 1967</u>	20d. INJURY OCCURRED <u>While at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Laurel Prince Georges Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dayton O. Watkins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>631 Sannapolis Rd Bleedensburg Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland Maryland</u>
24. FUNERAL DIRECTOR <u>GASCH'S</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1739 Baltimore Ave. Hyattsville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>MAY 26 1967</u>	

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[Faint, illegible handwritten text covering the majority of the page]

RECEIVED
JAN 10 1963
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07178

CERTIFICATE OF DEATH

08634

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 12 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7815 Valley Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Richards		4. DATE OF DEATH Month May Day 31 Year 19 67					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 May 1967	9. AGE (In years lost birthday) yrs. 12	IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min. 12		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E			14. MOTHER'S MAIDEN NAME Sonja Marie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7610 Fetal asphyxia DUE TO (b) Abrupted Placenta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from May 31, 1967 , to May 31, 1967 , that (I) (the) last saw the deceased alive on May 31, 1967 , and that death occurred at 1:40 AM from causes on and on the date stated above.							
22a. SIGNATURE Joseph A. Murgalo				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Joseph A. Murgalo, M. D.	
22d. ADDRESS 5813 Landover Rd. Cheverly, Maryland				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/10/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hqsp., Cheverly PG Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md.				25. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

7-245096

STATEMENT OF DEATH

John Doe

John Doe

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CERTIFICATE OF DEATH

Reg. Dist. No.

07157

07173

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4110 Cottage Terrace		d. STREET ADDRESS 4110 Cottage Terrace	
3. NAME OF DECEASED (Type or print) First HAMILTON Middle ROBERT Last SAGO		4. DATE OF DEATH Month May Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1890
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Sago	
14. MOTHER'S MAIDEN NAME Daisy O. Greene		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year or of unknown) Unk. (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 234 01 5846		INFORMANT Audrey F. Sago Same as #2 (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pul. Edema 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Emphysema DUE TO (c) allergic Bronchitis			INTERVAL BETWEEN ONSET AND DEATH 5-3-67 1957.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-29 , 19 67 to 5-3 , 19 67 , that I last saw the deceased alive on 5-3- , 19 67 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717-38th Ave Cottage City Md 207-22. DATE SIGNED 5-3-67 ACTUAL SIGNATURE George Haggage M.D. PHYSICIAN'S NAME (Type) Cottage City Md 207-22.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/8/67	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor P.G. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR MAY 8 1967	24b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

1933

1. Name of deceased: *John J. Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan. 15, 1888*
5. Place of birth: *New York City*
6. Usual residence: *123 Main St., New York City*
7. Cause of death: *Heart Disease*
8. Date of death: *Dec. 10, 1933*
9. Place of death: *Home*
10. Signature of attending physician: *[Signature]*
11. Signature of medical examiner: *[Signature]*
12. Signature of coroner: *[Signature]*

(111) 1234 5678 9101 2345 6789 1011 1213

13. Name of informant: *John J. Smith*
14. Relationship to deceased: *Self*
15. Date of information: *Dec. 10, 1933*
16. Place of information: *Home*
17. Signature of informant: *[Signature]*
18. Signature of registrar: *[Signature]*
19. Signature of clerk: *[Signature]*

20. Name of registrar: *John J. Smith*
21. Signature of registrar: *[Signature]*
22. Signature of clerk: *[Signature]*
23. Signature of informant: *[Signature]*
24. Signature of medical examiner: *[Signature]*
25. Signature of coroner: *[Signature]*

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

07180

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07158

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 3307 Chillum Road		
3. NAME OF DECEASED (Type or print) Charles Clark Sawyers			4. DATE OF DEATH May 20 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1911	9. AGE (In years last birthday) 55 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME James T. Sawyers			14. MOTHER'S MAIDEN NAME Ada Phillips		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World War II			16. SOCIAL SECURITY NO. 372-16-2427		
17. INFORMANT Evelyn Sawyers (Wife)			Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUBACUTE GLOMERULONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE PSEUDOMEMBRANOUS TRACHEITIS					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Cornelius J. Burns, MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> May 20, 1967 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting) Address (Street, city, town, or county) Cheverly, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/67	22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		24. REGISTRY REGISTRATION DATE MAY 24 1967	
24b. REGISTRAR'S SIGNATURE J. J. J. J.					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G389 6/12/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07159

07181

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4504 Payne Drive			
3. NAME OF DECEASED (Type or print) Alexander				4. DATE OF DEATH 5 19 67			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-1890	
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Florest		11. BIRTHPLACE (State or foreign country) Washington D. C.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Alice ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Emma Sharper Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gun shot wound of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head with .35 cal. revolver			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7:30am 5-19-67 ⁹				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Abandoned greenhouse, 6452 Lanham La., Camp Springs, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 5-19-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 22 May 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md	
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Road, Suitland, Maryland				25. REGISTRY REGISTRAR MAY 22 1967 DATE		25. REGISTRAR'S SIGNATURE Charles Judge	

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RETURN TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

RETURN TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07160

1. PLACE OF DEATH a. COUNTY Prince George	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	b. COUNTY Garrett
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt	c. LENGTH OF STAY IN 1b 4 mos.	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 125 - Hedgewood Drive	d. STREET ADDRESS Route 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Virgie	First Virgie	Middle E.
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5/14/1909	9. AGE (in years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 11 Days 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Harry Upole	14. MOTHER'S MAIDEN NAME Maude Lambert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT George Shaver - (Son)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma DUE TO (b) Carcinoma of breast DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from 3-22-67 , 19 67 , to 5-21- , 19 67 , that (I) (we) last saw the deceased alive on 5/6/67 , 19 67 , and that death occurred at 10 P M, from the causes and on the date stated above.	22a. SIGNATURE John J. Hughes
22b. DATE SIGNED 5-22-67	22c. PHYSICIAN'S NAME (Type) John J. Hughes	22d. ADDRESS 2141 - K St. N.W. Washington, D.C. 1 Suite 604
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/24/67	23c. NAME OF CEMETERY OR CREMATORY Vanverth Cem.
23d. LOCATION (City, town or county) (State) Freeport, W. Va.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.	ADDRESS Mt. Rainier Maryland	DATE MAY 25 1967

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07183

07161

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights 16-1			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS 7311 District Heights Parkway			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES Baby MICHAEL Boy Shoemaker				4. DATE OF DEATH 5 10 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1967	
9. AGE (In years lost birthday) yrs. 9		IF UNDER 1 YEAR Months 9		IF UNDER 24 HRS. Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Takoma Park, Maryland	
12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Frank Shoemaker				14. MOTHER'S MAIDEN NAME Patricia Russell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, none or unknown) No				16. SOCIAL SECURITY NO. N/A		17. INFORMANT Prince George County Welfare Board, Brentwood Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Aspiration of gastric contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Asphyxiated in crib after vomiting.			
20c. TIME OF INJURY Month, Day, Year 8:00 p.m. 5-10- 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 5-11-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF May 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Cemetery, Rt. #1, Laurel, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland				25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

07184

07162

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Resident of institution) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook d. STREET ADDRESS 6402 Seabrook Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elbert Middle L Last Silvers		4. DATE OF DEATH Month 5 Day 1 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Jan. 1924
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of life, even if retired) Lab. Tech.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Silvers		14. MOTHER'S MAIDEN NAME Beatrice Holder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWII		16. SOCIAL SECURITY NO.	
17. INFORMANT Address A. Marie Silvers Same as #2 (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Coronary artery occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201 (b) Atherosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 5-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/5/67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR WME 8 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

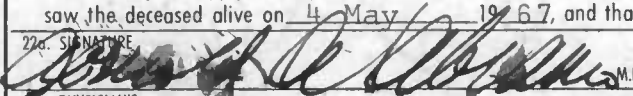

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07185

CERTIFICATE OF DEATH

07163

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE				c. LENGTH OF STAY in lb 5hrs49min			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 1034 BARNABY TERRACE			
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTOPHER (NMN) SIMMONS				4. DATE OF DEATH Month Day Year MAY 4 19 67			
5. SEX MALE	6. COLOR OR RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 MAY 1967	9. AGE (In years last birthday) 47.3	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. 5 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGES, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EUGENE SIMMONS				14. MOTHER'S MAIDEN NAME BARBARA A. WHITTAKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address FATHER, SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 4 May , 19 67 , to 4 May , 19 67 , that (X) (we) last saw the deceased alive on 4 May , 19 67 , and that death occurred at 2:45 PM from causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4 May 1967	
22c. PHYSICIAN'S NAME (Type) ARNOLD A. ABRAMO, LTCOL, USAF MC				22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/67		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		23d. LOCATION (City or Town) (County) (State) Fort Myer, Virginia	
24. FUNERAL DIRECTOR ALEXANDER S. POPE				ADDRESS 414 15th St. S.E.		25a. REC'D BY REGISTRAR MAY 11 1967	
				25b. REGISTRAR'S SIGNATURE 			

000000

STATE OF TEXAS

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THE STATE OF TEXAS, COUNTY OF DALLAS, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County Clerk of said County.

WITNESSED my hand and the seal of said County at Dallas, Texas, this 1st day of May, 1900.

CLERK OF COUNTY

139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07186

CERTIFICATE OF DEATH

07164

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 44 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 8913 Cherry Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last John W. Simms			4. DATE OF DEATH Month Day Year May 9, 1967		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/05	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min. 16.1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Robert Simms			14. MOTHER'S MAIDEN NAME Bessie Johnson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Marilyn Jones-2215 Rand Pl., N.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident - embolic 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Coronary Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Quintal Fibrillation					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from March 26, 1967 , to May 9, 1967 , that (he) (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 1 P.M. from causes and on the date stated above.					
22a. SIGNATURE Edwin Jensen M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 9, 1967
22c. PHYSICIAN'S NAME (Type) Edwin Jensen, M.D.			22d. ADDRESS Prince Georges General Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-67	23c. NAME OF CEMETERY OR CREMATORY Nat'l. Harmony Men. Pk. Landover, Maryland		23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Rollins		25a. REC'D BY REGISTRAR H339 Hunt Pl N.E. WASH, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

6815

2045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD. 21201 CERTIFICATE OF DEATH </div>																					
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>																
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>11 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights, 16-1</u>																
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>74 Prince George General Hospital</u>					d. STREET ADDRESS <u>2577--Colebrooke Dr., SE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>RUSSELL H. STAINBACK</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>11th</u> Year <u>19 67</u>																
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 7th, 1912</u>		9. AGE (In years last birthday) <u>54</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Mechanic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>North Carolina</u>													
13. FATHER'S NAME <u>William R. Stainback</u>					14. MOTHER'S MAIDEN NAME <u>Lessie Hicks</u>																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-20-0392</u>		17. INFORMANT <u>Bessie M. Stainback (Wife)</u>					Address <u>Same as Item #2</u>												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Phlebotrombosis</u> DUE TO (c) <u>Cirrhosis of liver</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>days</u> <u>3 years.</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>2 Umbilical Vein catheterization</u>																					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>May 1,</u> 19 <u>67</u> , to <u>May 11,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 11,</u> 19 <u>67</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above.																					
22a. SIGNATURE <u>John H. Bayly</u>					22b. DATE SIGNED <u>May 11-1967</u>																
22c. PHYSICIAN'S NAME (Type) <u>Dr. John H. Bayly</u>					22d. ADDRESS <u>Prince Georges General Hospital 1835--I--St., N. W., Wash. DC</u>																
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg, Md.</u>														
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>					25a. REC'D BY REGISTRAR <u>MAY 12 1967</u>																
ADDRESS <u>Simmons Bros. 1661-Good Hope Rd SE Wash DC</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																

81181

TO THE DIRECTOR, FBI
FROM THE SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a teletype message with several lines of information, including dates and names, but is mostly unreadable due to fading and bleed-through.]

Very truly yours,
[Illegible signature]
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07188

CERTIFICATE OF DEATH

07166

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		d. STREET ADDRESS 637 - 5th Street, N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Lola C. Starke		4. DATE OF DEATH Month Day Year May 14 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1882
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James M. Etter		14. MOTHER'S MAIDEN NAME Clara Six	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-44-8205	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1967 , to May 14, 1967 , that (I) (we) last saw the deceased alive on May 12, 1967 , and that death occurred at 4:28 M, from causes and on the date stated above.			
22a. SIGNATURE A K BOWIE M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A K BOWIE		22d. ADDRESS 301 - Constitution Ave. WASH. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-17-67	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR Francis J. Collins 2821-145 STNW DC		25a. REC'D BY REGISTRAR MAY 17 1967	
25b. REGISTRAR'S SIGNATURE f Charles Judge			

STATE OF TEXAS

1887

County of _____ State of _____

Know all men by these presents, _____ of the County of _____ State of _____

do hereby certify that _____ of the County of _____ State of _____

is the owner and possessor of the following described land, to-wit:

_____ Acres, more or less, situated in the _____

_____ of the _____

_____ of the County of _____ State of _____

_____ of the County of _____ State of _____

1887

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07183

CERTIFICATE OF DEATH

07167

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle S Last Steele		4. DATE OF DEATH Month May Day 15 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1904
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver	11. BIRTHPLACE (County & State, or foreign country) Virginia
10b. KIND OF BUSINESS OR INDUSTRY Grayhound co		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Steele		14. MOTHER'S MAIDEN NAME Dalton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 173 07 0719	
17. INFORMANT Kathryn Steele		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 443 X DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept-63 , 19__, to 11 May , 19 67 , that (I) (we) last saw the deceased alive on 11 May , 19 67 , and that death occurred at 6:10 AM from causes and on the date stated above.			
22a. SIGNATURE John Kehoe M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-16-67
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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4383

DEPARTMENT OF COMMERCE

2313

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

07190

CERTIFICATE OF DEATH

07168

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2820 Crest Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elsie Ann Stewart		4. DATE OF DEATH Month Day Year May 16, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/13
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley J. Gross		14. MOTHER'S MAIDEN NAME Ross G. Sinek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 201 05 6556	
17. INFORMANT Ralph W. Stewart Jr. Same as #2 (son)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x Metastatic Carcinoma DUE TO (b) Carcinoma of breast DUE TO (c) 6 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from May 16, 1967 , to May 16, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 2:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

77120

STATE OF TEXAS

COUNTY OF DALLAS

1911

IN SENATE,
January 11, 1911.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1909.
DALLAS: THE TEXAS
PRINTING CO., 1911.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G389 6/12/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07191

07169

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Washington D.C. 47-3		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 1838 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Melvin Stigger			4. DATE OF DEATH Month Day Year 5 27 19 67		
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-14/ 15	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Robert Daniel		
14. MOTHER'S MAIDEN NAME Lena Rawlings			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Lena Wallace-mother-5716 8th St., N.W.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8254 IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of brain, and DUE TO (c) Multiple fractures of legs and pelvis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in collision			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3:15am 5-27 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Woodrow Wilson Bridge, Prince George's, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-28-67	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park Maryland	
23d. LOCATION (City or Town) (County) (State) Stewart Funeral Home-4001 Penning Road, N.E.		23e. REC'D BY REGISTRAR DATE JUN 1 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07192		07170	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 5 YR.		WASHINGTON, D.C. 161	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANDREWS AIR FORCE BASE HOSP		d. STREET ADDRESS 1501-49TH AVE. S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DUSTY LANE STOCKING		4. DATE OF DEATH Month Day Year MAY 21 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 18 JAN 1962
9. AGE (In years lost birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE CO. MD.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME DAVID EDWARD STOCKING		14. MOTHER'S MAIDEN NAME VIRGINIA EVELYN TERO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DAVID EDWARD STOCKING - WASHINGTON, D.C.		Address 1501-49TH AVE. S.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS WITH MASTOIDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ACUTE LYMPHOBLASTIC LEUKEMIA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 33 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from JULY, 1966, to MAY, 1967, that (1) (we) last saw the deceased alive on 21, MAY 1967, and that death occurred at 5:40 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Paul H. Perlstein		22b. DATE SIGNED 21, MAY 1967	
22c. PHYSICIAN'S NAME (Type) PAUL H. PERLSTEIN		22d. ADDRESS CAPT USAF MS USAF HOSP ANDREWS AIR FORCE BASE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/25/67	23c. NAME OF CEMETERY OR CREMATORY SPRINGFIELD CENTER	23d. LOCATION (City or Town) (County) (State) SPRINGFIELD CENTER, NEW YORK
24. FUNERAL DIRECTOR ROBERT E. WILHELM 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR MAY 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

REPORT TO THE SECRETARY

1917

1

Very faint, illegible text covering the main body of the report, appearing to be a series of paragraphs or a list of items.

Name of the person or organization making the report		Name of the person or organization to which the report is made	
Address of the person or organization making the report		Address of the person or organization to which the report is made	
Date of the report		Date of the report	
Signature of the person making the report		Signature of the person to whom the report is made	
Title of the person making the report		Title of the person to whom the report is made	

Very faint, illegible text on the right margin, possibly a reference or a note.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
07193					CERTIFICATE OF DEATH					08653							
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine					c. LENGTH OF STAY IN lb 1-Hour					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Naylor							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brandywine-Waldorf Medical Center					d. STREET ADDRESS --					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Herbert Roy Trueman					4. DATE OF DEATH May 22, 1967												
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28, 1891		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Engineer Ice Company					10b. KIND OF BUSINESS OR INDUSTRY Employed					11. BIRTHPLACE (County & State, or foreign country) Maryland							
12. CITIZEN OF WHAT COUNTRY? U. S. A.					13. FATHER'S NAME Joshua C. Trueman					14. MOTHER'S MAIDEN NAME Mary Dixon							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO.					17. INFORMANT Flora D. Trueman- Naylor, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Surge attack DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 Day yes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from 5-10 , 19 67 , to 5-22 , 19 67 , that (II) (we) last saw the deceased alive on 5-22 19 67 , and that death occurred at 5:30 PM , from the causes and on the date stated above.																	
22a. SIGNATURE Richard Dobson, M.D.										22b. DATE SIGNED 5/22/67							
22c. PHYSICIAN'S NAME (Type) Richard Dobson, M.D.										22d. ADDRESS Brandywine, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					23b. DATE THEREOF 5/24/67					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory							
23d. LOCATION (City, town or county) Suitland					23e. (State) Maryland												
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.										25a. REC'D BY REGISTRAR JUN 9 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

27193

Prince George

May 1941

May 1941

May 1941

May 1941

May 1941

May 1941

May 1941

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March 28, 1941

May 1941

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2/22/47

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07194

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07171

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM 3. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 4305 Tonquil Place	
3. NAME OF DECEASED (Type or print) Cleve A Tucker		4. DATE OF DEATH 5 1 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1893
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR 1 Months 19 Days 67 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Pullman Co		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Yates Tucker		14. MOTHER'S MAIDEN NAME Martha M. Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 709-12-4961	
17. INFORMANT Hazel S. Mazzyck		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 5-1-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5.4.67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		23d. LOCATION (City or Town) (County) (State) Colmar Manor. Md	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E Wash D C.		25a. REC'D BY REGISTRAR MAY 4 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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CERTIFICATE OF DEATH

Reg. Dist. No. 07173

07195

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Marlow Heights)</u>		c. LENGTH OF STAY IN 1b <u>Suitland, (Marlow Heights)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4314 Townsley Ave.</u>		d. STREET ADDRESS <u>4314 Townsley</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cornell Campbell WAGNER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1967</u> <u>December 9</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 9, 1912</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>High School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education - Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlotte, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. of Am.</u>	
13. FATHER'S NAME <u>Clyde Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Louise Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>424-03-2030</u>	
17. INFORMANT Address <u>Mrs. Pearl Wagner, 4314 Townsley, Marlow Heights 20031</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure from Probable Coronary Occlusion</u> DUE TO <u>11201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic & Hypertensive Heart Disease</u> DUE TO <u>10 years</u> (c) <u>Arteriosclerosis Generalized</u> <u>15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Talked to Med. Examiner before signing this.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u> <u>—</u> <u>—</u>
21. I certify that I attended the deceased from <u>December 20, 1961</u> to <u>May 7, 1967</u> , that I last saw the deceased alive on <u>April 25, 1967</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4300 St. Barnabaz Road.</u> ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D. <u>—</u> PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson, M.D.</u> <u>Marlow Heights, Maryland 20031</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-11-1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. W.</u> Address <u>4308 Suitland Road Suitland Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 11 1967</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(Maximum Height)

4314 Towarley Ave.

11442

December 8, 1912

Clyde Wadner
Geoffrey Louis Campbell

[Faint handwritten notes at the bottom of the page]

Arteriosclerosis Generalized
Arteriosclerosis & Hypertensive Heart Disease
Heart Failure from Probable Coronary Disease

Talked 2 Med. Examiners before signing this.

10 05 1964

1891

Walter W. Gordon, M.D.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07174

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN TB <u>DOA</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hosp.</u>			d. STREET ADDRESS <u>5914 2nd. Ave.</u>		
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Waldersak</u> Middle <u>Walderzak</u> Last			4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 Dec. 1966</u>	9. AGE (In years lost birthday) <u>5</u> yrs.	10. IF UNDER 1 YEAR Months <u>5</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Waldersak</u>			14. MOTHER'S MAIDEN NAME <u>Sharon Hudson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Robert Walderzak</u> Address <u>Same As # 2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningococcal Meningitis</u> <u>057.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Waterhouse Friderichsen Syndrome</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, city, town, or county) <u>5-18-67</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Maryland</u>		
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u> <u>4308 Suitland Road, Suitland, Maryland</u>			25. REC'D BY REGISTRAR <u>MAY 22 1967</u> DATE		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

6-1977

07173

07173

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project's progress. It includes a list of the tasks that have been completed and a list of the tasks that are still pending.

3. The third part of the report is a discussion of the project's results. It includes a list of the findings that have been obtained and a list of the conclusions that have been drawn.

4. The fourth part of the report is a list of references. It includes a list of the books, articles, and other sources that have been consulted during the project.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film #G389 5/23/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07197

07175

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS Hillcrest Heights 16-1			
3. NAME OF DECEASED (Type or print) First Harry Middle Walsh Last Walsh				4. DATE OF DEATH Month 5 Day 15 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Sept. 1889		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR (Months) Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Plasterer		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Walsh				14. MOTHER'S MAIDEN NAME Alice Goth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mary E. Lyles same as # 2.D Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 154X DUE TO Carcinoma of the rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH over 3 mo.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 5-15-67		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5.18.67		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07198

07176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY in 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6905 Central Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Welch				4. DATE OF DEATH Month Day Year May 25, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1910	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi-Driver				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (County & State, or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JAMES WELCH				14. MOTHER'S MAIDEN NAME LAURA WELCH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address LOUIS WELCH, North Beach, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b); and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xx (this hospital) attended the deceased from May 11, 1967 , to May 25, 1967 , that xx (we) last saw the deceased alive on May 25, 1967 , and that death occurred at 9:53 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Reynaldo Lee Llacer</i>				22b. DATE SIGNED 5/27/67		22c. PHYSICIAN'S NAME (Type) Reynaldo Lee Llacer	
22d. ADDRESS Prince Georges General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-67		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND	
24. FUNERAL DIRECTOR GASCH'S				25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Prince Georges General Hospital

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May 15, 1957

May 15, 1957

Prince Georges General Hospital

Prince Georges General Hospital

May 15, 1957

May 15, 1957

May 15, 1957

May 15, 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07193

07177

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Gen. Hospital</u>		d. STREET ADDRESS <u>409 Trenton St. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>H.</u> Last <u>Wells</u>		4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1909</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINT-CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clement W. Wells</u>		14. MOTHER'S MAIDEN NAME <u>Louise Connelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WWII</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen E. Wells - SAME AS ITEM #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4200</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes over 4 no.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>5-18-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>MAY 20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Md</u>
24. FUNERAL DIRECTOR <u>Seamus Bro. 1661-Good Hope Rd SE. WASH DC</u>		25a. REC'D BY REGISTRAR <u>MAY 22 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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9-6-67 ams

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07178

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District Of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 1401 Gerard St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Stanley Henry White			4. DATE OF DEATH Month Day Year 5 22 19 67		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1928	9. AGE (In years lost birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 434.3 DUE TO Fibronous pericarditis with pericardial effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT-RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which overturned			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5:40 p.m. x May 19 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 214	20f. (City or town) Prince G. Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 5-23-67	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5-27-67	23c. NAME OF CEMETERY OR CREMATORY Harmon	23d. LOCATION (City or Town) (County) (State) Md		
24. FUNERAL DIRECTOR W.H. Bacon 3447-14th St. NW			25a. REC'D BY REGISTRAR MAY 25 1967		
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

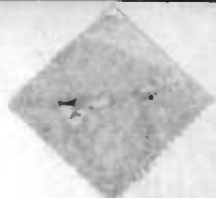
07201

CERTIFICATE OF DEATH

07179

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 77 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 7421 Simpson Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ralph Middle I. Last Windsor, Sr.			4. DATE OF DEATH Month May Day 20 , Year 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/03	9. AGE (In years birthday) yrs. 63	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Postal Dept.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William H. Windsor			14. MOTHER'S MAIDEN NAME Ida Mae King		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Della C. Windsor-Wife Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cadine arrest 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of esophagus					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 4 , 19 67 , to May 20 , 19 67 , that (I) (we) last saw the deceased alive on May 20 , 19 67 , and that death occurred at 4:15 AM , from causes and on the date stated above.					
22a. SIGNATURE Bahram Erfan			22b. DATE SIGNED 5-20-67		
22c. PHYSICIAN'S NAME (Type) Bahram Erfan, M.D.			22d. ADDRESS 6813 Riverdale Rd., Riverdale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 23-1967	23c. NAME OF CEMETERY OR CREMATORY Bells Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Camp Springs, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS Simmons Bros.-1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR MAY 22 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



07201

ESTIMATE OF DEATH

Married

Prince George's

Clinton

17 days

Chesley

701 Simpson Lane

Prince George's General Hospital

20 May

May

Windsor, Sp.

I.

John

88

11-23-03

White

Male

Windsor

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

May 20

May 20

March 9

May 20

May 20

Prince George's General Hospital

Prince George's General Hospital

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07202

CERTIFICATE OF DEATH

07180

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <input checked="" type="checkbox"/> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b XXXX 7 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. <i>47-3</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1419 Chapin St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle A. Last Woodbridge				4. DATE OF DEATH Month May Day 9 Year 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1880		9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) unknown Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Adams				14. MOTHER'S MAIDEN NAME Neillie F. Adams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-03-9724		17. INFORMANT decendent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with extensive metastases 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/23/ 19 66 , to 5/9/ 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/9/ 19 67 , and that death occurred at 10:15AM from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/9/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Wash. National		23d. LOCATION (City or Town) (County) (State) Suitland, MD	
24. FUNERAL DIRECTOR W.W. Chambers Co. Inc				ADDRESS 1400 Chapin St. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR MAY 15 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2203

STATE OF NEW YORK

James H. Jones

James H. Jones (husband)

James H. Jones, U.S.

James H. Jones

James H. Jones, U.S.

James H. Jones

James H. Jones

James H. Jones

James H. Jones

James H. Jones

James H. Jones

James H. Jones

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James H. Jones

James H. Jones

James H. Jones

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07203

CERTIFICATE OF DEATH

07181

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u>		d. STREET ADDRESS <u>4210 BROOKFIELD DR.</u>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE</u> First Middle Last <u>WRIGHT</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/81</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BAVARIA, GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALOYSIUS DIENINGER</u>		14. MOTHER'S MAIDEN NAME <u>ANTOINETTE PFHALMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-14-5694</u>	
17. INFORMANT Address <u>SISTER ELIZABETH CARROLL MANOR</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLUS</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>HYPERTENSION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>2 years</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-27</u> , 19 <u>65</u> to <u>5-12</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>MAY 12, 1967</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F Collins</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>		22d. ADDRESS <u>322- H ST NE.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR <u>Nalleys Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>

42173

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

42173

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07204

CERTIFICATE OF DEATH

07182

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 12 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6160 Spring Hill Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William XXX Amar Wynn Sr.				4. DATE OF DEATH Month Day Year May 15, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/29/01		9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister			10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME W. R. Wynn				14. MOTHER'S MAIDEN NAME Minnie Walton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 709-09-7379		17. INFORMANT Duella S. Wynn Address 6160 Spring Hill Terrace Greenbelt, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelo-nephritis (Acute) DUE TO (c) fracture							INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PARALYSIS ACITANS - PARKINSONISM							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from -- , 19 65 , to May 15, 1967 , that (I) (we) last saw the deceased alive on May 15, 1967 , and that death occurred at 8:05 M. from causes and on the date stated above.							
22a. SIGNATURE Albert Roth				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 15, 1967	
22c. PHYSICIAN'S NAME (Type) Albert Roth, M.D.				22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF May 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, Georgia	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 17 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

5210

4095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07183

FOR STATE
HEALTH DEPT.

07205

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 6702 96th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Casper Francis Zimmer				4. DATE OF DEATH Month Day Year 5 28 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-88		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Zimmer				14. MOTHER'S MAIDEN NAME Grace Kuhn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -		16. SOCIAL SECURITY NO. 579-10-5345		17. INFORMANT Mrs. Catherine O. Zimmer (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				(Wife) address)		INTERVAL BETWEEN ONSET AND DEATH Minutes over 1 yr.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 5-28-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE JUN 5 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07206

CERTIFICATE OF DEATH

07184

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 58 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael - Zimmerman, Jr.		4. DATE OF DEATH Month Day Year May 24, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/95
9. AGE (In years lost birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME MICHAEL ZIMMERMAN		14. MOTHER'S MAIDEN NAME ANNA RUSHKUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W.B.S. W.W.I		16. SOCIAL SECURITY NO. 294-03 4938	
17. INFORMANT MARY JOHANNA ZIMMERMAN		Address SAME AS 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac insufficiency 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma left lung DUE TO (c) 6 months			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) person attended the deceased from - , 19 60 , to May 24, 1967 , that (I) person last saw the deceased alive on May 24, 1967 , and that death occurred at 8:15A AM, from causes and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED May 24, 1967	
22c. PHYSICIAN'S NAME (Type) Peter Duus, M. D.		22d. ADDRESS 6124 Central Ave. Capitol Hghts. Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-27-1967	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, Md.		25a. REC'D BY REGISTRAR MAY 26 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

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